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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

00000				MAN ELSER
1. PLACE OF DEATH				If institution: Residence before admission)
Carroll	MARYLAND	a. STATE Mar	yland b. cou	Carroll
b. CITY OR TOWN (if outside corporate limits, write RURAL and give neerest lown)	c. LENGTH OF STAY IN 16	c. CITY OR TOWN	(If outside corporate limits, wr	ite RURAL and give necrost town]
Rural Mt.Airv	18 Months	Rural	Mt.Airv	06-1
d. NAME OF HOSPITAL OR INSTITUTION (if not in		d. STREET ADDRES		e. IS RESIDENCE
R.F.D. # 2		R.	F.D. # 2	YES NO K
3. NAME OF First	Middle	Last	4. DATE Mor	nth Dey Yeer
(Type or print) Roland	E. I	Babylon	DESCRI	an. 5 1966
5. SEX 6. COLOR OR RACE 7. MA		DATE OF BIRTH	9. AGE (In year	IF UNDER TYEAR IF UNDER 24 HRS.
	WED DIVORCED	Oct.30 19	last birthday	Months Days Hours Min.
10e. USUAL OCCUPATION (Give kind of work   10	L KIND OF BUSINESS OR INDUSTRY		unty & State, or foreign countr	y) 12. CITIZEN OF WHAT COUNTRY
dona during most of working life, even if retirad)	Duillaine	Comm	oll Co. Md.	U.S.A.
Carpenter	Building	14. MOTHER'S MAIDE		U.D.R.
Taganh Dah	7	Tra o	rence L. Ph	illine
Joseph Bab			) refice T. Lii	TTTT 12
(Yas, no, or unkown) (Ifyesgive wer or detes of service)			7 Daharlan	Some on # 2
18. CAUSE OF DEATH (Enter only one cause)		rs Mary	Babylon	Same as # 2
				ONSET AND DEATH
IMMEDIATE CAUSE (a) Ca	rdiac fibrillation	on		1964
4331 DUE TO				iem 1-5-66
	rdiac failure wi	th massive	cerebral embol	15m 1-3-00
(e), stating the underlying DUE TO				
	bolism to both for			
Z PART II. OTHER SIGNIFICANT CONDITIONS	CONTRIBUTING TO DEATH BUT NO	T RELATED TO THE TERM	MINAL DISEASE CONDITION G	IVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?
15				YES NO
OR CONTRIBUTING CAUSE OF DEATH	DESCRIBE HOW INJURY OCCURED.	(Enter neture of injury i	in Pert I or Pert II of item 18.)	
				(6)
		CE OF INJURY (Home, to cry, streat, office bldg., e	arm, 20f. (City or town)	(County) (State)
₹ p.m. 19 et	work at work			
21. I certify that (I) (this hospital) at	tended the deceased from		, 19.64 to Jan. 5	
saw the deceased alive on Jana 5	19.66 , and that	deeth occured at.	11:45 from the cause	
220. SIGNATURES Howard &	Hall "		MED. STAFF DIRECTOR PHYS.	Jan. 7, 1966 SIGNED
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		
Howard E. Hal	1, M.D.	Syk	esville, Maryl	
23a. BURIAL, CREMATION, 23b. DATE THEREOF	23c. NAME OF CEMETERY	OR CREMATORY	23d, LOCATION (City,	lown or county) (Stelle)
Burial Jam. 8 196	6 Bethesda Co	emetery	Carroll	Co. Md.
24 FUNERAL DIRECTOR'S SIGNATURE	ADDRESS		REC'D BY REGISTRAR 25h	
C.M. Waltz Box 241 S	vkesville. Md	WAN	10 1966	walls Judge

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abetal cultistic findens sylman drive suches without

relative Granes Stor of malipho

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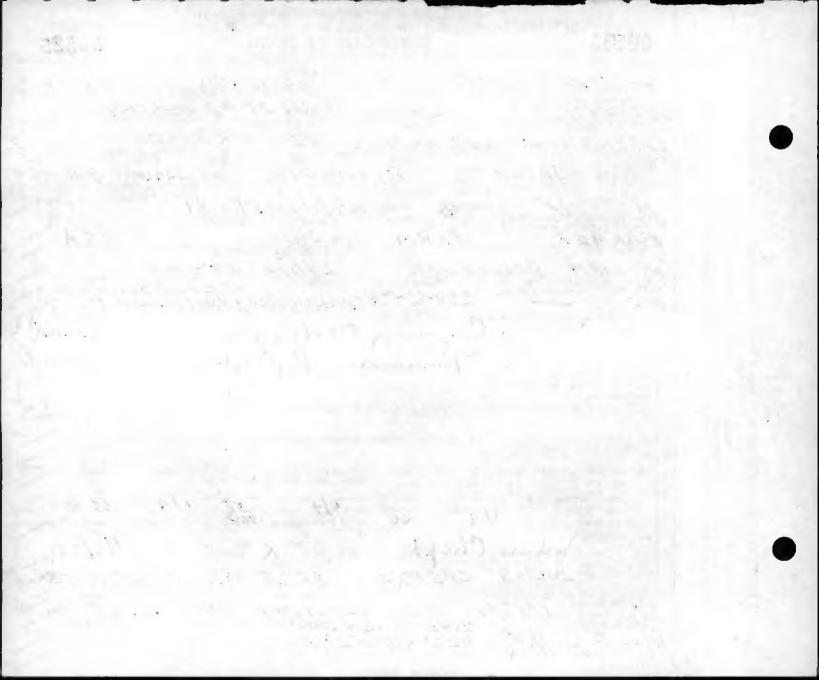
Survival in the city

n w y e

BIND SE Up at 1 2005 4 7715 TO 3 .... and a great company In Jean Van Case 0.00 

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VR AI5 (4) 20M 1/65



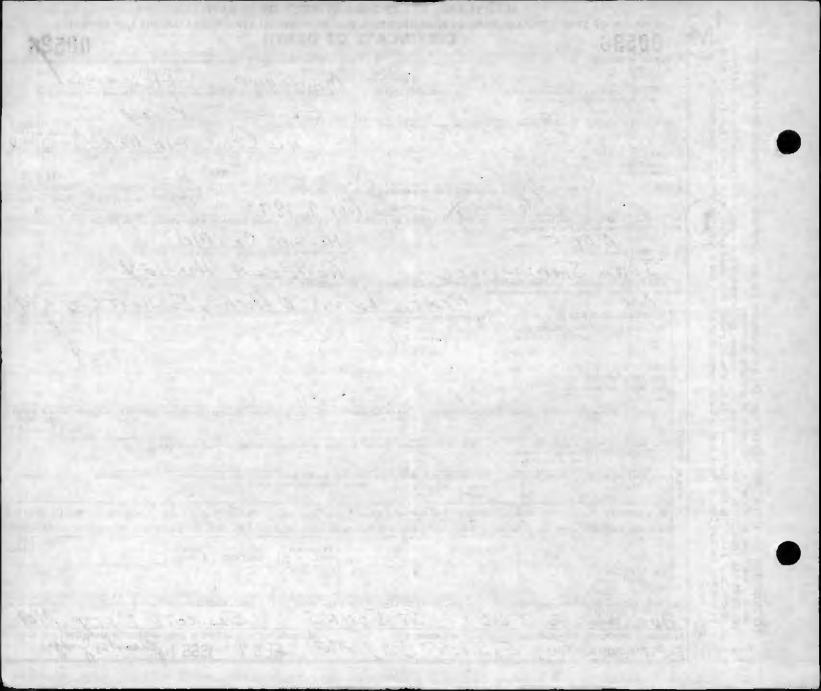
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) e. COUNTY hours b. COUNTY by the and 2 death. OWAR MARYLAND b. CITY OR TOWN (if outside corporate limits, CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b Write RURAL and give nearest town) E \* after LLICO Pages within filled d, NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) d. STREET ADDRESS . IS RESIDENCE ON A FARM? hours YES NO D completely papers. n 72 ho NAME OF 3. Middle DATE Day Month Year DECEASED OF (Type or print) DEATH 196 pou 6. COLOR OR RACE 7. MARRIED NEVER MARRIED S. SEX 8. DATE OF BIRTH AGE (In years HE UNDER 1 YEAR IF UNDER 24 HRS pue fast birthday) Months Hours eyept, WIDOWED DIVORCED certificate physician remove 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY? BIRTHPLACE (County & State, or foreign country) 11. done during most of working life, even if retired) 4 40 WARID ON please 13. FATHER'S NAME death .5 altending and Then 15. WAS DECEASED EYER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT removal, unkown) i (Ifvestrivewarm dates of service) that Φ £ permit. physiciam 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN signed by ONSET AND DEATH 5 PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cremation, burial-transit DUE TO affending The law peen Conditions, if any, which gave rise to immediate cause DUE TO (a), stating the underlying has burial, the PHYSICIAN: ò PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6): 19, WAS AUTOPSY certificate CERTIFICATION hospital SE 0 PERFORMED? NO T for use prior 20a. ACCIDENT WAS UNDERLYING [ 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18.) he OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) After this Health detached MEDICAL be retained by ATTENDING 20c. TIME OF INJURY Month, Day, Year 20d, INJURY OCCURRED | 20e, PLACE OF INJURY (Home, farm, ) 20f. (City or town) (State) (County) factory, street, office bldg., etc.) While Not While Hour a.m. ö at work at work 19 DIRECTOR: Dept. should be 21. I certify that (I) (this hospital) attended the deceased from ...? 19 ....., that (I) (we) last to State M, from the causes and on the date stated above, saw the deceased alive on... .... and that death occurred at .... тау 22a. SIGNATURE 22b. DATE SIGNED ATTENDING. PHYS. DIRECTOR PHYS. FUNERAL M.D. HOSPITAL page with t 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type director, be filed 236. BURIAL, CREMATION, | 236. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (State) SEMOVAL (Specify) o 1196 24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

Elianles

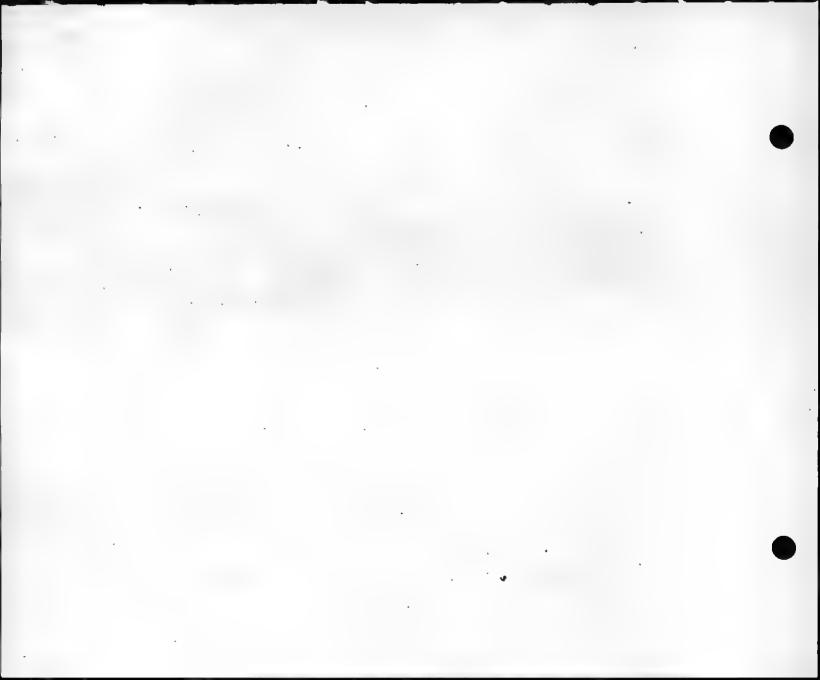
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DATE

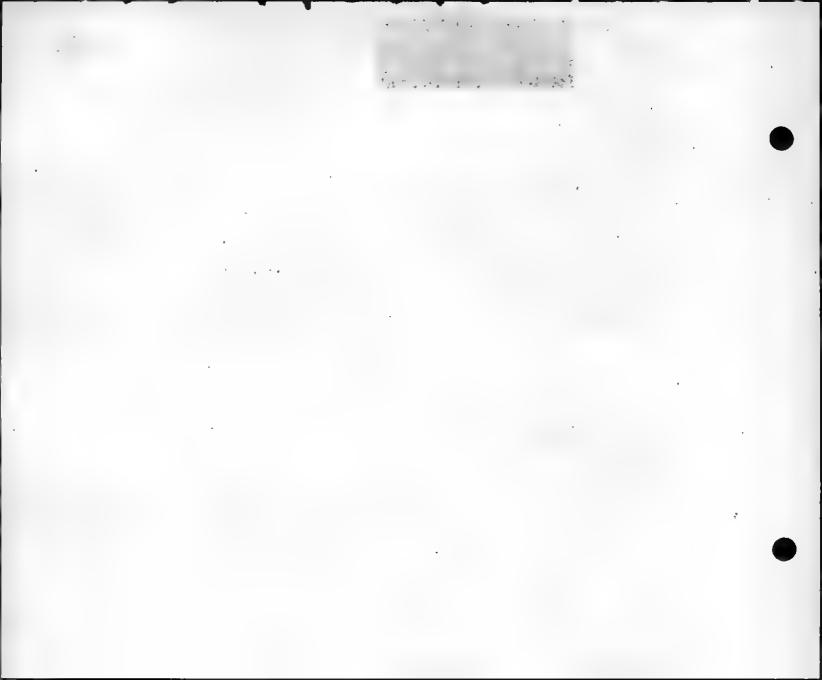
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			DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
	a/v		00537 CERTIFICATE OF DEATH (1)0527
	death death	月五	PLACE OF DEATH   2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission
	2 2		B. COUNTY CARROLL MARYLAND B. STATE B. COUNTY CARROLL MARYLAND
-	by the Pages urs aft		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
	in by in by S. Pag		INTECT MINESTER 20 HOURS WESTMINESTER RURAL
	t hour led in sers.		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  d. STREET ADDRESS  e. IS RESIDENC ON A FARM?
) ,	within 24 hours after death letely filled in by the functaron papers. Pages 1, and 4, within 72 hours after death	0/	ARRILL CO GENERAL HISPITAL LINIUNTOWN RIAD YES NOS
	within 2. pletely fill arbon pag it, within	3.	NAME DF First Middle Last   4. DATE Month Oay Year
•	it abe		DECEASED (Type or print) CARRIE ZEMORA BUFFINGTON DEATH / 6 1966
7	e ve	5.	SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. OATE OF BIRTH 9. AGE (In years   IFUNDER 1 YEAR   IFUNDER 24 HR last birthday) Months   Oays   Hours   Min
1	any ev		WIDOWED DIVORCED SEP 7 25 - 1965 60 yrs. Months Days Hours Min
	E	10: du	a. USUAL OCCUPATION (Give kind of workdone) 1Db. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY?
	cate be physician please ral, and in	"	HOUSE KEEPER OWN HOME MARYLAND 4.A
	phy n ply val,	13	FATHER'S NAME 14. MOTHER'S MAIOEN NAME
	eath certifica attending pl ermit. Then n, or remova		CHARLES C CRABBS AMELIA COPENHAVER
	tend iit.	15 (Y	S. WAS DECEASED EVER IN U.S. ARMED FORCES?   16. SOCIAL SECURITY NO.   17. INFORMANT Address R3 MD
	The law requires that the death certificate be or attending physician. ate has been signed by the attending physicial use as the burial-transit permit. Then please alth prior to burial, cremation, or removal, and		NO EMORY BUFFINGTON WESTMINSTER
	the de nation		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).]  INTERVAL BETWEEN ONSET AND DEATH
	an. an. 1 by ransi		PART I. DEATH WAS CAUSED BY: CEREBRAL VASCULAR ACCIDENT 34 HOURS
	es that physician signed urial-tra urial, cr		4 2 2 / DUE TO
	law requires that attending physician has been signed e as the burial-tra h prior to burial, cr		Conditions, If any, which ) O) HRTERIOSCLEROTIC C'ARDIOVASCULAR
	required ding I ding I been the E the E r to t		gave rise to immediate cause (a), stating the OUE TO
	law re ittendi has b as tl prior	2	underlying cause last. (c)
	e la att	101	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)   19. WAS AUTOPSY PERFORMED?
			ICHEUMATIC HEART DISEASE YES NO
	CIAN: The ospital or a certificate ned for usu	CERTIFICATION	2Da. ACCIDENT WAS UNDERLYING (20b. OESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING (20b. OESCRIBE HOW INJURY OCCURRED.)
	PHYSICIAN: the hospital this certifi detached fo e Dept. of H		(IF EITHER, NOTIFY MEDICAL EXAMINER)  20c. TIME OF INJURY Month, Day, Year I 20d. INJURY OCCURRED   20e. PLACE OF INJURY (Home, farm,   20f. (City or town) (County) (State)
	E e t t t t t t t t t t t t t t t t t t	MEDICAL	20c. TIME OF INJURY Month, Day, Year   20d. INJURY OCCURRED   20e. PLACE OF INJURY (Home, farm, factory, street, office bidg., etc.)   (County) (State)
	Star be at the star of the sta	Æ	p.m. 19   at work
	. OR ATTENDING y be retained by DIRECTOR: Afte age 3 should be lied with the Sta		21. I certify that (I) (this hospital) attended the deceased from 1966, and that death occurred at 43M, from the causes and on the date stated above
	State of the state		saw the deceased alive on
	d y de		Where I from M.o. ATTENDING OF MED. STAFF 1/6/66
	ral or nay be al. Dir page page filed		22e, PHYSICIAN'S   22d, ADORESS
	TO HOSPITAL OR ATTEN Page 4 may be retaine TO FUNERAL DIRECTOR: director, page 3 should should be filed with the		NAME (Type) DR VINCENT J FLOCCO WESTMINSTER MD
	Page Page FUN direct should	23	
	5g 5g 2		BURLAL 1/9/66 LUTHERAN UNICHTOWN MO
	PK	24	The state of the s
	VR AI5 (4) 2DM 1/65	2	ON Hartzler & Soul Men Windsor, Mit MAN 10 1936 Menorles & rige
	STAIN IN /		



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND



To FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages J-and-2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. TO ROSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND OUSSION

CERTIFICATE OF

DEATH				0.0	52	1
SUAL RESIDENCE (Where d	leceased		Institution:	Residence	before	1

1	1.	PLACE OF DEATH a. COUNTY Carroll	2. USUAL RESIDENC a. STATE	_ ` .	deceased lived, If In: b. COUI	YTY			
		b. CITY OR TDWN (If outside corporate limits, write RURAL and give nearest town)  C. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If	rland outside c	orporate limits, wr			omer; a neares	
١	( p.	ural) Sykesville lyr Om 3 da	Silver	Sur	ing /	_	^-		
1		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)	d. STREET ADDRESS				6.	IS RESI	DENCE ARM?
,	S	pringfield State Hospital	2103 Be	lved	ere Boule	evard	50	SOP	
1	3.	NAME DF First Middle	Last	4. DAT			Day 29	Yea	r 66
1	-	(Type or print) Truman ROSS CI	ssel	DEA		le (INDE	-	19	
ı	٥.	7. MARKIED ALVER MARKIED	9-3-1880		9. AGE (in years clast birthday)	Months	Days	Hours	Min.
ł	10a	IISIIAI OCCUPATION (Cive kind of work done   10h KIND OF BUSINESS OF	11. BIRTHPLACE (Ce	umtu & Cto	угѕ.		TIZEN O	E WHAT	
	dur	ing most of working life, even if retired)  Merchant - Ketired INDUSTRY Self employ.	1	•	te, w integriounte;	Č	SA SA		
1	13.	FATHER'S NAME	14. MOTHER'S MAID		- 01	_	- TO 0		
1		Wilbur Cissel	Helen F.		7 *** * * *	,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	BK	ow.	<i>n</i> .
	15 (Ye	. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY ND. 17. s, no, or unknown) (If yes give war or dates of service)	INFORMANTA DO	roth	C. Letun	Euch!	5.5	5 . , /	Md.
	_		Hoom talk Re	cora	5 2103 Be	weder		VAL BET	DUCCH
		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY:					ONSE	T AND D	DEATH
		IMMEDIATE CAUSE (a) Heart failure and	klaney Tal.	Lure.			WKS	OF	mos.
		Conditions, If any, which ) DUE TO  Arteriosclerotic	heart diseas	58.			yea	rs	
		gave rise to immediate	110-10 4,200-1				7 44	• <del>V</del>	
		cause (a), stating the underlying cause last. ) (c) Nephrosclerosis.					vea	rs	
	ATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELA Chronic Brain Syndrome associated w	TED TO THE TERMINAL D ith cerebra	SEASE CO	portion given in terio-	PART 1(a)	1	WAS AU PERFOR!	MED?
2	CERTIFICATION	Sclerosis with psychotic reaction 202. ACCIDENT WAS UNDERLYING   200. DESCRIBE HOW INJURY OCCU DIF CINTRIBUTING   CAUSE OF DEATH (IF CINTRIBUTING OF DEATH (IF CINTRIBUTING OF DEATH (IF CINTRIBUTING OF DEATH (IF CINTRIBUTING OF DEATH (IF CINTRIB	RRED. (Enter nature of	injury in	Part I or Part II o	of Item 18.		x	ND [
			CE OF INJURY (Home, fa	200	(City or town)	(Cou	néu\	/9	tate)
	MEDICAL	Hour a.m.  p.m. 19   While at work   at work   at work	ry, street, office bldg., et	tc.)		(000		(3	tate)
		21. I certify that (1) (this hospital) attended the deceased from	1-26 , je	965 , t		, 19_6			
		saw the deceased alive on 1-29 1966, and that	death occurred at	15AM,	from the causes				above.
İ		22a. SIGNATURE	ATTENDING	MED. DIRECTOR	STAFF ICA	22b. D/	AIL SIGI	NED	3011
		22c. PHYSICIAN'S M.D	1 22d. ADDRESS			1400	×, ,_)	17,1	760
		NAME (Type) Frances Reid Nabors	Springfiel	ld St	ate Hosp	ital			
	23a	BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY	OR CREMATORY	23d.	LOCATION (City, t	own or col	inty)	(St	ate)
		REMOVAL (Society) 2-4-66 St. Marks Enil	Conctery	R	Pairland,	Mary	day	1	
1	24	FUNERAL DIRECTOR SULTA GEORGIA AUG	25a. REC	C'D BY RE	GISTRAR   25b. R	EGISTRAR"	S SIGNA		
1	-0	Takrer E. Pumphrey, Ind. Silver Spring,		1	1966	- Fry C	9	7	

VR AI5 (4) 20M 1/65



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please certification papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. executed within 24 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
()()53()

	20		OLICITI TOAT	L OI DEATH	•	1110011	
1. PLACE OF E	EATH				CE (Where deceased lived, If Ins		mission)
Carro	11		MARYLAND	a STATE Maryland	Baltino	ore City	
b. CITY OR write RI	TOWN (if outside corporate IRAL and give nearest town)	limits,	C. LENGTH OF STAY IN 16		outside corporate limits, wr		town)
Sykes	ville		15 dys.	Baltimon	re . 3	1 . 4	
d. NAME O	HOSPITAL OR INSTITUTION	(if not In ho	spital, give street address)	d. STREET AOORESS	2 labe Dr au	B. IS RESIG	OENCE
	gfield State H		1	90		8C YES 1	NO X
3. NAME DF DECEASED	First	t	Middle	Last	4. DATE Month	ı Oay Year	٢
(Type or pr		I		COHEN	DEATH JA NUA		
5. SEX	6. COLOR OR RACE 7	MARRIEO	NEVER MARRIEO	8. OATE OF BIRTH		IF UNDER 1 YEAR IF UNDER : Months   Oays   Hours	24 HRS. Min.
Male	White	MIDOWED		10-17-1894	71 yrs.		IYLUI
10a, USUAL OCC	UPATION (Give kind of work do working life, even if retired)	ne 10b. Ki	NO OF BUSINESS OR DUSTRY	11. BIRTHPLACE (C	ounty & State, or foreign country	12. CITIZEN OF WHAT	
Sales	man			Maryland	ì	U.S.A.	
13. FATHER'S	NAME	<u> </u>		14. MOTHER'S MAIL			
¹ Jo	seph Cohen			J. (12	ast name_unk.)_		
15. WAS DECEA	SED EVER IN U.S. ARMED FORCE WITH THE SERVICE OF SERVIC	CES? 16.	SOCIAL SECURITY NO.   17.	INFORMANT	Addres	S	
Yes	1918	civice)	7-19-7-9303	Records, Sm	ringfield State	Hospital	
18. CAUSE	OF DEATH [Enter only one of				2.0522024 04,04	INTERVAL BETY	WEEN
	I. OEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			neumonia ma	ceiva	Davs	EATH
441	X OUE TO		oran Drononop.	it danie i i za	OOL V.C	Days	
Conditions	if any, which						
gave rise	to Immediate				·		
	cause last.						
		SCONTRIBU	TING TO OEATH BUT NOT RELA	TEO TO THE TERMINAL O	DISEASE CONDITION GIVEN IN	PART 1(a) 19. WAS AUT	OPSY
CAT						PERFORM	VIED? NO FET
PART II. OTI	ENT WAS UNDERLYING	20b. D	ESCRIBE HOW INJURY OCCU	JRREO. (Enter nature of	Injury In Part I or Part II o		(2)
	BUTING   CAUSE OF DEATH , NOTIFY MEDICAL EXAMINE	R)					
	OF INJURY Month, Oay, Ye	ar [ 20d. IN	JURY OCCURRED   20e. PLA	CE OF INJURY (Home, fa	rm, 20f. (City or town)	(County) (St	tate)
Nour Hour	a.m. p.m. 19	While at work	MOT WALLS -	ry, street, office bldg., e	tc.)		
	ertify that (I) (this hospita			1-10-66	n to 1-25-66	19 that (I) (we	e) last
		25-66		death occurred at	9 to 1-25-00 SOUN from the causes:	and on the date stated a	above.
22a. SIGN		. />	1/)	death obcurred ac		22b. DATE SIGNED	db o to s
	Man	o a	VIULE M.C	ATTENDING TO	MEO. DIRECTOR PHYS.	1-26-66	
	ICIAN'S E (Type)				pringfield Sta	te Hospital	
	Octavio	A. Rui	z, M. D.	S	ykesville, Mar	yland	
23a. BURIAL, C	REMATION, 23b. DATE THE	EREOF	23c. NAME OF CEMETER	OR CREMATORY	23de LOCATION (City, to	wn or county) (Sta	ite)
Bur		6-	Chezop ll	myno	Pallo 1	nel	
24. FUNERAL	DIRECTOR / Lb / M	Red	AODRESS	25a. REC		GISTRAR'S SIGNATURE	,
Sol.	Terrison	150	os line	DATEFF	B 1 1966 A	Charles Judge	_
					A MAN		

VR AI5 (4) 20M 1/65 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

		00541			CERTIFI	CAT	E OF DEATH			0.05	31	
	1.	PLACE OF DEATE a. COUNTY	Carrell		Many	AND	2. USUAL RESIDENCE a, STATE	E (Where deceased	lived, If instit	belto.	City	imission)
		b. CITY DR TDW Write RURAL Sykesvi	N (if outside corpora and give neasest too	rte limits, <b>T)</b>	c. LENGTH OF STAY 23yr 6m	IN 1b	c. CITY DR TDWN (If	outside corporat	e limits, write	RURAL and g	ive neares	t town)
			gfield Sta		ospital, give street ac	idress)	d. STREET ACCRESS 1208Greys	tone Rd.			-	IOENCE FARM3 ND
		NAME DF DECEASED (Type or print)	Agnes	irst	Middle G.		ogan Last	4. DATE DF DEATH	Month	Da	19	66
	Fe	sex emale	6. COLOR DR RACE White	WIDDWED	DIVORCED	$' \square \Gamma$	3-22-77	86	yrs.		Hours	Min.
	dur	ing most of work	ng life, even if retire	HOME	(IND OF BUSINESS OR Noustry		11. BIRTHPLACE (CI	rk	reign country)	U.S. CITIZEN	OF WHAT	
	13.	FATHER'S NAM	noethy c	JAMES	FINNERT	r	14. MOTHER MAID	ELL	en Ly	ONS		
			EVER IN U.S. ARMED FO (If yes give war or dates)		. SDCIAL SECURITYND.		INFORMANT Cords Sprin	efield He	Address Sy	kesvill	Le. Me	d.
		PART I. DE	any, which ) Immediate ( ating the DUE	(a) <b>ATT</b> CI TO (b)	riecclerati	e Ca	rdio Vascul	ar Diseas	ie	1	SET AND	
	SATION			ONS CONTRIB			reaction,				WAS AU PERFOR	MED?
7	CERTIFICATION	2Da. ACCIDENT	WAS UNDERLYING THE CAUSE OF OFFI	1 20b.	DESCRIBE HOW INJUR	Y OCCU	RRED. (Enter nature of	Injury In Part I	or Part II of			
	MEDICAL	20c. TIME OF Hour a.m		Year   2Dd.   While at wor	Not While	facto	CE DF INJURY (Home, fa ry, street, office bldg., e	tc.)		(County)	(5	State)
		saw the dea	eased alive on	pital) attend L=1-66	led the deceased fr		0=16=42 , 10 death occurred at 3		<b>1-66</b> he causes at	., 19, i	hat (I) (v te stated	ve) last above.
		228. SIGNATU	En Toni	ms.	Giar	~	ATTENDING PHYS.	MED. DIRECTOR [ ]	TAFF PHYS.	1-1-6	GNED	
		22c. PHYSICIA NAME (T)	re) Antonie	ıs Glah	n, M.D.		225ykesvil	le, Mary	land			
	23a	REMDVAL (Spe	ATION, 23b. DATE	THEREDF	23c. NAME OF CE	-		23d. LOCATI	ON (City, tow	n or county)	(\$1	tate)
B	24 Fi	FUNERAL DIRE		805	AOORESS		- 444	C'D BY REGISTRA	000	ETRAR'S STO		
	4.1	• # • 1125 A	vo a nov	000	N. CALVE	CRT	ST. DATEAN	4 196	0 11	corcio )	udge	*

VR A15 (4) 20M 1/65





e. IS RESIDENCE ON A FARM?

YES NO K

1966

IF UNDER 24 HRS

INTERVAL BETWEEN ONSET AND DEATH

19. WAS AUTOPSY

PERFORMED? NO

(State)

22b. DATE

(Stata)

Day

21

U.S.A.

(County)

VR A15 [4] 20M 5-63



00544

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and example tely filled in by the funeral director, page 3 should to detacled for une and the limital-transit mermit. Then please remove carbon papers. Pages 1 and 2- should be lied with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. 24 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Page 4 may be retained by the hospital or attending physician.

> VR A15 (4) 15M 4-64

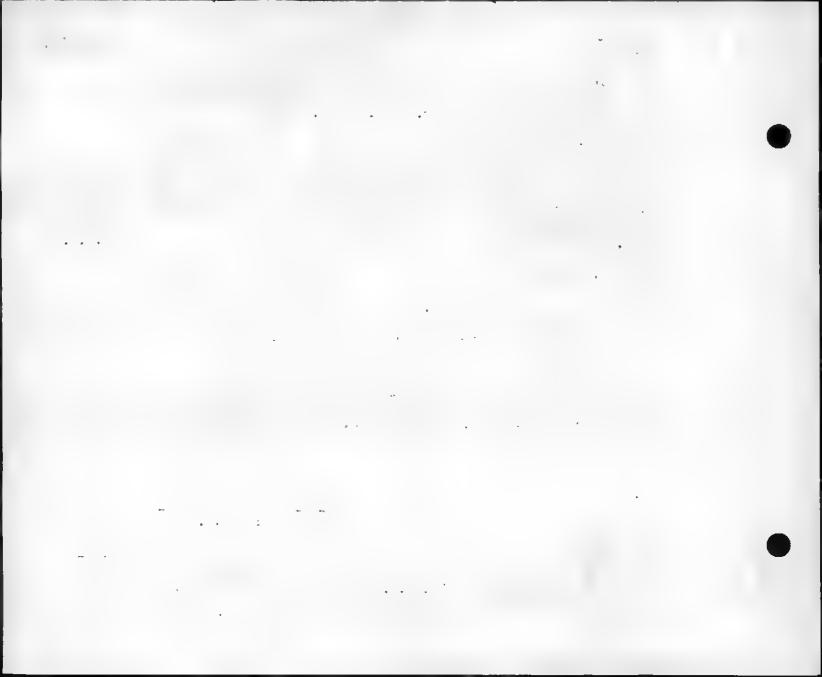
## MARYLAND STATE DEPARTMENT OF HEALTH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND (1) (1) 534 DIVISION OF STATISTICAL RESEARCH CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY			a. STATE	E (Where deceased lived, If Institution  b. COUNTY	tion: Residence before admission)
Carroll		MARYLAND	Haryla	nd l'a:	shington
b. CITY OR TOWN (if outside write RURAL end give nea Sykesville	corporate limits, rest town)	6 mos. 1 d		outside corporete limits, write i	RURAL and give nearest town)
d. NAME OF HOSPITAL OR INS				00 WII	e. IS RESIDENCE
Springfield St	tate Hospital	L	Route	#1	YES ND
3. NAME DF DECEASED	First	Middle	Last	4. DATE Month	Day Year
(Type or print)	ERIE	HALET	DE HART	DEATH January	v 1 1966
5. SEX 6. COLOR O	R RACE   7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years IFI	INDER 1 YEAR IF UNDER 24 HRS.
Male White		DIVORCED	11-25-90	last birthday) Mo 75 yrs.	
IDa. USUAL DCCUPATION (Give kind during most of working life, even	lof work done   10b. KINI If retired)   IND	D OF BUSINESS OR USTRY	11. BIRTHPLACE (Co	unty & State, or foreign country)	12, CITIZEN OF WHAT COUNTRY?
Mailroad Engine	er W.M	R.R.	"irgini,	a Patrick Co.	U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAID		
	.Rufus Dehar		likt klokkt	Lausey A.Bo	wers
15. WAS DECEASED EVER IN U.S. A (Yes, no, or unkown)   (If yes give war	RMED FORCES?   16. SO	CIAL SECURITY NO. 1	, INFORMANT	Address	
10	70	1-10-6782	Records, Spri	ngfield State Ho	oscital
18. CAUSE DF DEATH [Enter	ronly one cause per line	for (a), (b), and (c).]			INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAI	USED BY: Arte	erioscleroti	c cardiovascu	lar disease	Veare
4221	DIJE TD				
Conditions, if any, which	(b)				
gave rise to immediate	DUE TO			-	
cause (a), stating the (					
	(c) CONDITIONS CONTRIBUTI	NG TO DEATH BUT NOT R	LATED TO THE TERMINAL D	ISEASE CONDITION GIVEN IN PAR	PERFORMED?
151				Internal Death of Back II of M	YES NO 2
PARTIL OTHER SIGNIFICANT OF THE	YING 20b. DES OF DEATH L EXAMINER)	SCRIBE HOW INJURY OF	CURRED. (Enter nature of	injury in Part 1 or Part II of it	em 18.)
S 2Dc. TIME OF INJURY Mont	th, Day, Year   2Dd. INJI		LACE OF INJURY (Home, fa		(County) (State)
ZDc. TIME OF INJURY Mont	19 While at work	Not While at work	ctory, street, office bldg., et	C.)	
21. I certify that (I) (t)	The second secon		7-3-65	to 1-4-66	19, that (I) (we) last
saw the deceased alive			nat death occurred at	M, from the causes and	In the date stated above
22a. SIGNATURE	7		iat death occorred at		2b. DATE SIGNED
Ca	ani a	Kring	I.D. PHYS.	MED. STAFF DIRECTOR PHYS.	1-5-66
22c. PHYSICIAN'S NAME (Type)		N. D.		pringfield State	
	vio A. Ruiz,			ykesville, Maryl	
23a. BURIAL, CREMATION, 23b. REMOVAL (Specify)	_	23c. NAME OF CEMETI REST HAVE	RY OR CREMATORY	HACERS TOWN	4
24 FUNERAL DIRECTOR		ADDRESS		D BY REGISTRAR   25b. REGI	STRAR'S SIGNATURE
11	resa Charco	I Tom HARE EN	TOWN, MO. DATAN	6 1966 Jalia	wee Judge
MAST MAUEN JULY	KAL CHALLE	Jane Tilleks	1000 / WILLIAMETT	<u>u</u>	- U



	MARYLAND STATE DEPARTMENT OF HEALTH	
DIVISION OF	STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, I	
00545	CERTIFICATE OF DEATH	00535

_	and the second	<u> </u>	1 0 0 0 0 0 1 1 1 1 1	·		70000
1,	PLACE OF DEATH a. COUNTY			CE (Where deceased lived,		sidence before admission)
	Carroll	MARYLAND	a. STATE		COUNTY Montgon	nawir /
-	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1	c. CITY OR TOWN (If	outside corporate limit	s, write RURAL a	and give nearest town)
		9 yr. 3 mo.	_		1	
-	Sykesville d. NAME OF HOSPITAL OR INSTITUTION (If not in		W -		1	e. IS RESIDENCE
						ON A FARM?
-	Springfield State Hos	pital	48T5	North Lane		YES NO X
3.	NAME OF First DECEASED	Middle	Last	4. DATE	Month	Day Year
	(Type or print) WINONA	MARGARET	EBERHART	DEATH JE	anuary 1	
5.	SEX 6. COLOR OR RACE 7. MARRII	ED NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In ye	Bars IFUNDER 1	YEAR IF UNDER 24 HRS
	Female White WIDOW	ED DIVORCED	7-17-03	62	day) Months I	Days Hours Mill'
108	. USUAL OCCUPATION (Give kind of work done   10b.	. KIND OF BUSINESS OR	11. BIRTHPLACE (C	county & State, or foreign co	puntry)   12, C[]	TIZEN OF WHAT
qur	ing most of working life, even if retired)	INDUSTRY	Indian	n A	i Çu	UNTRY?
13.	FATHER'S NAME		14. MOTHER'S MAIL			
	David C. Eberhart		Jannatt	e Fertich		
15		6. SOCIAL SECURITY NO. 1 17	7. INFORMANT		ddress	
(Ŷĕ	s, no, or unkown) (If yes give war or dates of service)					
_	No	Unk.	Records, Spi	ringfield Sta	ate Hosp	
	18. CAUSE OF DEATH (Enter only one cause pe	r line for (a), (b), and (c).1				INTERVAL BETWEEN ONSET AND DEATH
	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) AC1	ite myocardial	infarction			days
Н	DUE TO					
П	Conditions, if any, which \ (b) Con	ronary occlusio	מור			davs
Ш	gave rise to immediate (					
	underlying cause last.	teriosclerotic	heart diseas	e		years
NO.	PART II. OTHER SIGNIFICANT CONDITIONS CONTRI	BUTING TO DEATH BUT NOT RE	LATED TO THE TERMINAL I	DISEASE CONDITION GIVE	N IN PART 1(a)	19. WAS AUTOPSY
ΙĘΙ	Schizophrenic reaction	, paranoid typ	Θ.			PERFORMED?
ΙĔΙ	20a. ACCIDENT WAS UNDERLYING 20b.	DESCRIBE HOW INJURY OC	CHRRED (Enter nature of	f Injury In Part I or Part	t II of Item 18.1	
12	OR CONTRIBUTING TI CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	DESCRIBE NON INTOKT OC	COUNTED. (EIITOR HATOIO O	inguly and art i of each	, 11 01 110/11 201)	
MEDICAL CERTIFICATION						in the second
2	Dave a m	fac	LACE OF INJURY (Home, factory, street, office bldg., e	arm, 20f. (City or tow	rn) (Cour	nty) (State)
MEL	p.m. 19 at w	IS THE TANK AND THE TANK			4.4	
	21. I certify that (I) (this hospital) atter	nded the deceased from	10-15-56	9 - to- 1-18-	-55 19	, that (1) (we) last
Ш	saw the deceased alive on 1-18-6	6 and the	hat death occurred at			e date stated above
Н	22a. SIGNATURE	Dian				TE SIGNED
Ш	Dr. Chartonius	Malin	ATTENDING PHYS.	MED. STAFF DIRECTOR PHYS.	TX 1-	18-66
	22c. PHYSICIAN'S			pringfield	State Ho	spital
	NAME (Type) Antonius	Grahn M.D.		Sykasville, l		
23a	BURIAL CREMATION 23b. DATE THEREOF		RY OR CREMATORY	23d. LOCATION (C)		
	REMOVAL (Specify)	11 Clay 1	1400 000	D RAITIS	400/-	Med
24	FUNERAL DIRECTOR.	ADDRESS	258. RE	C'D BY REGISTRAR, 25L	. REGISTRAR'S	SIGNATURE
1	1 007 091	DE Des	(n 11/1/11)	0 = 15 .5	-	· Vice LK
1/	ewell Tunner / Come	2 ///200RC/	C/E/DATES	11 1 1 1 1 1		11 11



maletely filled in by the funeral cabon papers. Pages 1 and 2 ept, within 72 hours after death. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. IN FUNERAL DIRECTER: Lifer tells cartificate has meen signed by the afterding physician and conditional director, page 3 should be detached for use as the burial-transit permit. Then please removes, should be filed with the State Dept. of Heafth prior to burial, cremation, or removal, and in any me TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the Page 4 may be retained by the hospital or attending physician.

VR AI5 (4) 20M 1/65 MARYLAND STATE DEPARTMENT OF HEALTH
Division of statistical research and records, 301 w. preston street, baltimore 1, maryland
D0546 CERTIFICATE OF DEATH

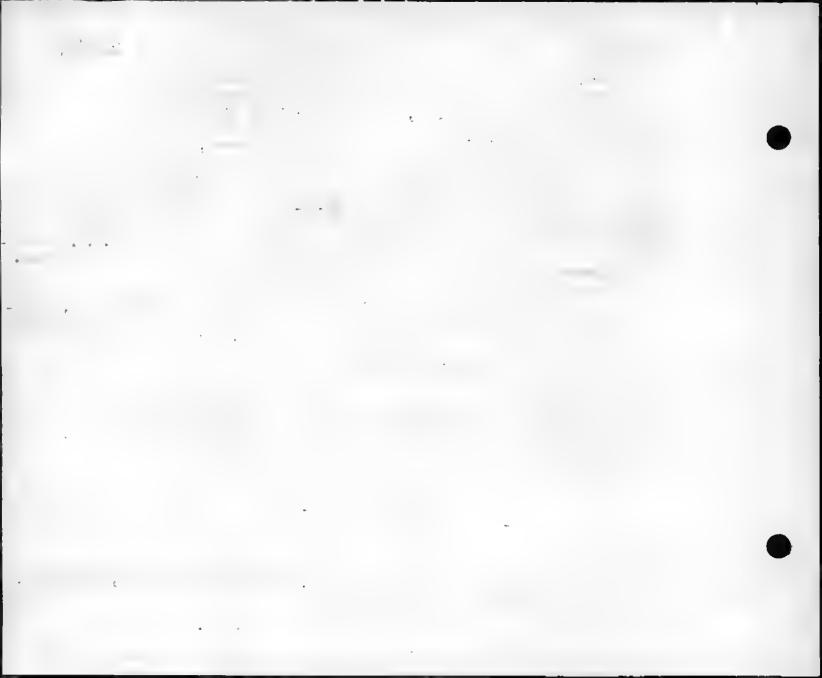
1. PLACE DE DEATH	2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. COUNTY Carroll MARYLAND	n, STATE b. COUNTY
b. CITY OR TOWN (if outside corporate limits, Rural and give nearest town)  MARYLAND  C. LENGTH OF STAY IN 1b	Maryland c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Sykesyille 2mo.27 days	Baltimore 30 - 4
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS  O. IS RESIDENCE ON A FARM?
Springfield State Hospital	4616 Manordene Road YES NO W
3. NAME OF First Middle DECEASED (Type or print) Florence Elizabeth Ellis	Last 4. DATE Month Cay Year OF DEATH Jan 2 1966
	DATE OF RIRTH 19 AGE (In years LIFTINDER 1 YEAR RETUNDER 24 HRS.
21 Miles and Market an	9-3- 87 Age birthday) Menths Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY?
At home	Maryland U.S.A.
13. FATHER'S NAME	
John J . Corbitt	Elizabeth McGeeney
John J Corbitt 15. WAS DECEASED EVER IN U.S. ARMED FORCES?   16, SOCIAL SECURITY NO.   17.	INFORMANI
No (If yes the war or dates of service) 212-09-1052 No s	Flizabeth McGeeney Address pringfield Hpsp. Records Sykesville, Md.
18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN OMSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pere (e Carel	liac faelure
Cenditions, If any, which ) OF Pater and Corollar (	actionsceller Dicease
gave rise to immediate	
underlying cause last.	one :4454 with *Cereberal
PARTH OTHER SECNIFICANT CONDITIONS CONTRIBUTING TO GEATH BUT NOT RELA	TED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMEO?
Brain Syndrome Associated wi	th Cerebral Arteriosclerosis PERFORMEO? YES NO PERFORMEO?
PARTH OTHERS IGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELA Brain Syndrome Associated wi with behavioral reaction  20a. ACCIDENT WAS UNDERLYING   20b. DESCRIBE HOW INJURY OCCU OR CONTRIBUTING   CAUSE OF DEATH (IF EITHER, NOTIFF MEDICAL EXAMINER)	RREO. (Enter nature of Injury In Part I or Part II of Item 18.)
1 tactor	CE OF INJURY (Home, farm, 20f. (City or town) (County) (State) ry, street, office bldg., etc.)
Hour a.m. While Not While p.m. 19 at work at work	Al an and arman gradul agail
	t.6, 1965, toJan. 2, 1966, that (1) (we) last
	death occurred at M, from the causes and on the date stated above.
22a. SIGNATURE	22b. DATE SIGNED
( Sopred C). Allele M.D	ATTENDING MEO. DIRECTOR DISTAFF DI TAN 21966
22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
Robert N. Deeb	
23a. BURIAL, CREMATION, 23b. OATE THEREOF   23c. NAME OF CEMETERY	OR CREMATORY 23d, LOCATION (City, town or county) (State)
Burin 1-5-65 NEW CATHEUN	en Balto Mo
24. FUNERAL DIRECTOR ADORESS	25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
Chas E. EVANS FORM 8802 HARFORD 1	d DOTAN 4 1966 Clientes Judge
	1999 //

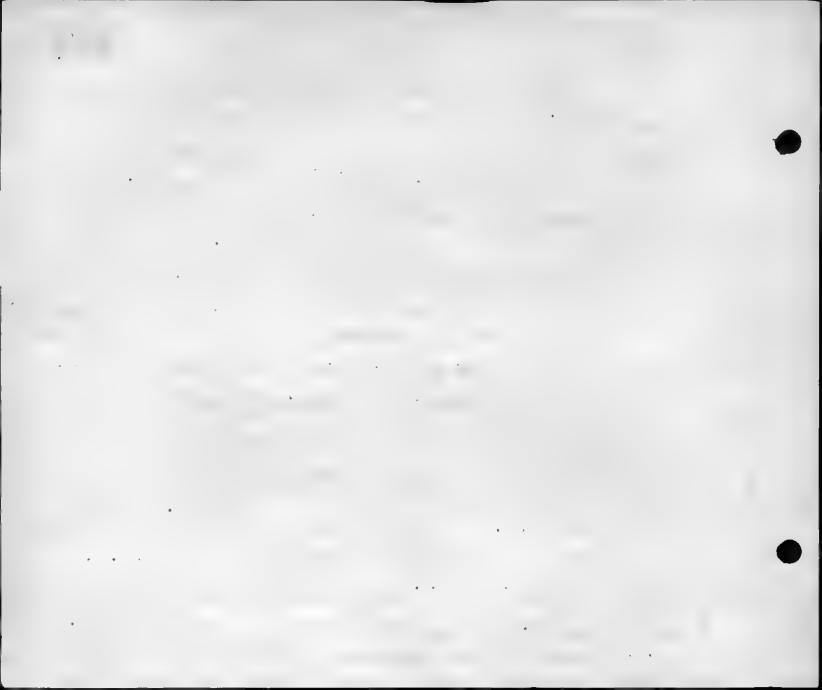


DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MARYLAND CERTIFICATE OF DEATH funeral should U PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if Institution, Residence before edm sslori) e. COUNTY **b.** COUNTY the d b. CITY ON TOWN (if outside corporate limits, MARYLAND E. LENGTH OF STAY IN 16 limits, write RURAL and give neerest town) c. CITY OR TOWN (V outside corporate write RURAL and give nearest town) STREET ADDRESS filled NAME OF HOSPITAL OR INSTITUTION (if not In hospital, give street address a. IS RESIDENCE ON A FARM? YES NO D completely NAME OF Middle Year DECEASED OP (Type or print) DEATH 19 AGE (In years | IF UNDER 1 YEAR 5. SEX 6. COLOR/OR RACE 7. MARRIED 8. DATE OF BIRTH IF UNDER 24 HRS NEVER MARRIED last birthday) Months Hours WIDOWED IX DIVORCED JSUAL OCCUPATION (Give kind of work BUSINESS OR INDUSTRY 12. CITIZEN OF WHAT COUNTRY? 1Db. KIND OF or forei country done during most of working life, even if retired) physic THER'S NAME affending WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yas, no, or unkown) (If yes give we ror detes of service) INTERVAL BETWEEN ONSET AND BEATH 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (e) DUE TO Conditions, if eny, which gove rise to immediate cause DUE TO (e), stoting the underlying cause last. certificate PART IL OTHER SIGNIFICANT CONDITIONS CONTRIBLYING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON GIVEN IN PART I(\*) 19. WAS AUTOPSY PERFORMED? NO X 020 CERTIFI 200 ACCIDENT WAS UNDERLYING TO OR CONTRIBUTING TO CAUSE OF DEATH 2Db. DESCRIBE HOW INJURY OCCURED, (Enter nature of njury in Port I or Port II of Item 18.) (IF EITHER, NOTITY-MEDICAL EXAMINER) (Steta) 20c. TIME OF INJURY 20d. INJURY OCCURRED | 2De. PLACE Of INJURY (Home, farm, (County) Month, Dev. Yeer 201, (City or town) factory, street, office bldg., etc.) Hour e.m. Wh le Not While p mu TRECTOR: 1.8., 196.6, that (1) (we) last 21. I certify that (I) (this (hospital) attended the deceased from (in the continuous) 6., and that teath occured at 32.M. from the causes and on the date stated above saw the deceased 22b. DATE 22e S GNATURE ATTENDING: MED SIGNED DIRECTOR PHYS PHY5. FUNERAL PHYSICIAN 22d. ADDRESS NAME (Type) director, be filed CREMATION, 231 23c. NAME OF 23d. LOCATION (City, town or county) (State) DATE THEREOF CREMATORY REMOYAL (Specify) 0 BY REGISTRAR 25b. 24 FUNERAL DIRECTOR'S SIGNATURE VR A15 (4) 15M 7/61



VR A15 (4) 15M 4-64

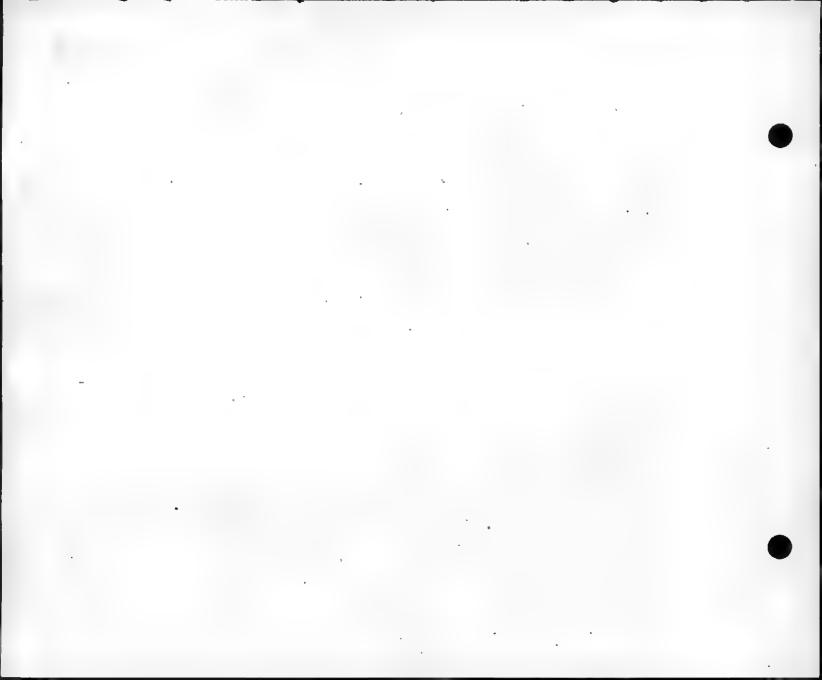




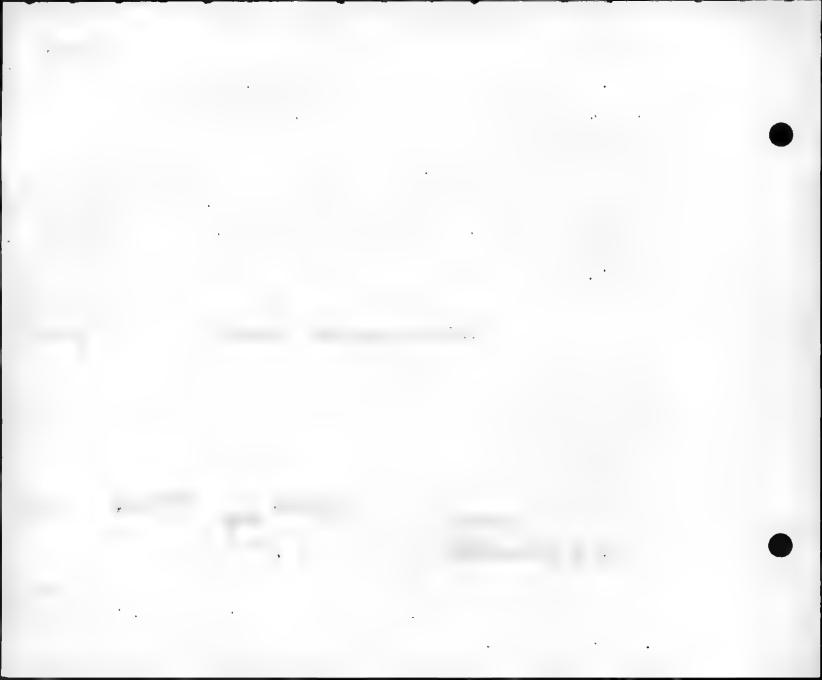
## MARYLAND STATE DEPARTMENT OF HEALTH

	DIVISION OF STATISTICAL RESEARCH AND RECORD	IS, 301 W. PRESTON STREET, BALTIMORE 1, M	IARYLAND
	00550 CERTIFICAT	TE OF DEATH	0540
1,	a. COUNTY CARROLL MARYLAND	2. USUAL RESIDENCE (Where deceased lived, If Institution: R a. STATE b. COUNTY	ROLL
	b. CITY OR TOWN (if outside corporate limits, write RURA; and give nearest town)  25 Years	c. CITY OR TOWN (if outside corporate limits, write RURAL	and give nearest town)
-	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address	d. STREET ADDRESS	e. IS RESIDENCE
_	•	MAIN ST.	ON A FARM? YES NO X
3.	NAME OF DECEASED (Type or print) DAVID W. GA	PEEN DATE Month OF DEATH JAN,	Day Year / 19 6-6
5.	SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED NEVER MARRIED DIVORCED DIVORCED	8. DATE OF BIRTH 9. AGE (In years IFUNDER last birthday) Months 85 yrs.	Days Hours Min.
10 du	a. USUAL OCCUPATION (Give kind of work done in the most of working life, even it retired)  FARMER RETURN OF BUSINESS OR INDUSTRY	D C	UNTRY?
13	THOMAS P GREEN'S	14. MOTHER'S MAIDEN NAME  MARY BOWSER	>
1: (Y	5. WAS DECEASED EVER IN U.S. ARMED FORCES? es, mo, or unknown) (If yes give war or dates of service)	RICHARD GREEN - WOODE	Blist Md
F	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c), ]	7,107	I INTERVAL BETWEEN
	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thromb	osis	ONSET AND DEATH
	by 2.1 Due to		1960
	Conditions, if any, which \ (b) Arteriosclertic	heart disease	through
	gave rise to immediate {     cause (a), stating the } DUE TO		1-17-66
		s, generalized.	
CERTIFICATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RE		19. WAS AUTOPSY PERFORMED? YES NO
	20a. ACCIDENT WAS UNDERLYING   20b. DESCRIBE HOW INJURY OCCONTRIBUTING   CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	CURRED. (Enter nature of injury in Part I or Part II of Item 18.	.)
MEDICAL		ACE OF INJURY (Home, farm, 20f. (City or town) (Coutory, street, office bidg., etc.)	inty) (State)
AED A	Hour a.m. While Not While p.m. 19 lat work at work	toriting and an analysis of the state of the	
-	21. I certify that (I) (this hospital) attended the deceased from	19 60, to Jan. 17, 19 6	that (I) (we) last
		at death occurred at 1.2 AM, from the causes and on the	he date stated above.
	22a. SIGNATURE	ATTENDING TO MED. STAFF	AN. 18, 1966
	22c. PHYSICIAN'S NAME (Type) HOWARD E. HANN	22d. ADDRESS SYXT-SYINAT.	1211011160
23	BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETE	RY OR CREMATORY   23d. LOCATION (City, town or con	unty) (State)
	BURIAL ISPECTION 1-20-66 ADDISON		4,
2	EUNERAL DIRECTOR ADDRESS	Say A Lange Of some	'S SIGNATURE
17	which I Attilled Junional	2 /1/1/ nd N 2 ± 1956 1 inequely	· Muchan

VR AI5 (4) 20M 1/65



4	1	DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
یے	= 0 E	00551 CERTIFICATE OF DEATH
after death.	funeral and 2 death.	PLACE DF DEATH a. CDUNTY b. COUNTY c. STATE b. COUNTY c. STATE
9	the fu	MARYLAND MARYLAND MARYLAND MARYLAND
	by the f Pages 1 urs after	b. CITY DR TDWN (if outside corporate limits, write RURAL and give nearest town write RURAL and give nearest town)
2100	in b Pour	NEW WINDSOR RURAL VEARS WIFW WINDSON KURHE "1
24 hours	lled pers 72	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)  d. STREET ADDRESS  e. IS RESIDENCE DN A FARM?
	ly fill part thin	YES NO YES NO NAME OF First Middle Last 14. DATE Month Day Year
The law requires that the death certificate be executed within	olete arbor t, wi	DECEASED CITYPE OF PRINT THOMAS HILL DAY YEAR DEATH JAN 25 1966
B	omp e co	6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years   FUNDER 1 YEAR   FUNDER 24 HR
ecul	nd o mov any e	M CCL WIDDWED DIVORCED DFC 24-1877 88 yrs.
8	e re in a	Oa, USUAL OCCUPATION (Give kind of work done uring most of working life, even if retired)  12. CITIZEN OF WHAT COUNTRY?  COUNTRY?
ق ق	sici; leas and	LABORER HOTEL LABORER MARYLAND USA
ficat		13. FATHER'S NAME
erti	SE E	SAMUEL HILL BESS  15. WAS DECEASED EVER IN U.S. ARMED FORCES?   16. SDCIAL SECURITY ND.   17. INFORMANT Address
<b>4</b>	mit.	Yes, no, or unknown) (If yes give war or dates of service) NONE FLSIF HILL NEW WINDSOR MD
dea	he a per tion	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  INTERVAL BETWEEN ONSET AND DEATH
‡	n. by t ansit ram:	PART I, DEATH WAS CAUSED BY: Uniterioscleratio CVD years.
that	ned ned al-tra al, ca	of a ac / Due to
S	phys signature buria	Conditions, If any, which (b)
nba	Jing been the r to	gave rise to immediate cause (a), stating the DUE TO
aw r	tenc as as prio	underlying cause last. (c) PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?
le le	the hospital or attending physician, this certificate has been signed b detached for use as the burial-tran e Bept. of Health prior to burial, cre	PART II. DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)  PERFORMED?  YES NO  DR. CONTRIBUTING CAUSE OF DEATH  (IF EITHER, NOTIFY MEDICAL EXAMINER)  19. WAS ADJUPCT PERFORMED?  YES NO  CONTRIBUTION OF INJURY OF INJURY OF INJURY OF INJURY OF INJURY IN Part 1 or Part II of Item 18.)
<u>ت</u>	ital tifical Ference	2Da. ACCIDENT WAS UNDERLYING 2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part II of Item 18.)
ICIA	cer cer shed	
PHYSICIAN	the this this letac	20c. TIME DF INJURY Month, Day, Year Hour a.m. p.m. 19   An work   Not While at work
8	by f fter be o State	
ATTENDING	ined R: A Suld the S	21. I certify that (I) (this hospital) attended the deceased from 7/1/30, 19 to the deceased from that (I) (we'll saw the deceased alive no 1/24/4/4 19 and that death pocurred at 1/24/4/4 from the causes and on the date stated above
E	CTO Showith	22a. SIGNATURE   22b. DATE SIGNED
<b>8</b>	DIRE ge 3 ed v	M.D. PHYS. DIRECTOR D
TAL	may IAL I	22c. PHYSICIAN'S NAME (Type)  A D T C
D HOSPITAL OR ATTENDING	Se 4	THE ROBLAISON NEW VILLOSON THE
O HOSPITAL	Page 4 may be retained by the hospital or attending physician.  10 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pag should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours	REMOVAL (Specify)
_	2	PIR 1171 1/28/1966 MT OLIVE WEW VIIIDSON SONAL MILE 24. FUNERAL DIRECTOR ADDRESS 25a. REGISTRAR'S SIGNATURE
VI	R AI5 (4)	100 Hartely & Sono Theur U indow partAN 28 1956 Periodes Judge
	OM 1/65	KN 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1





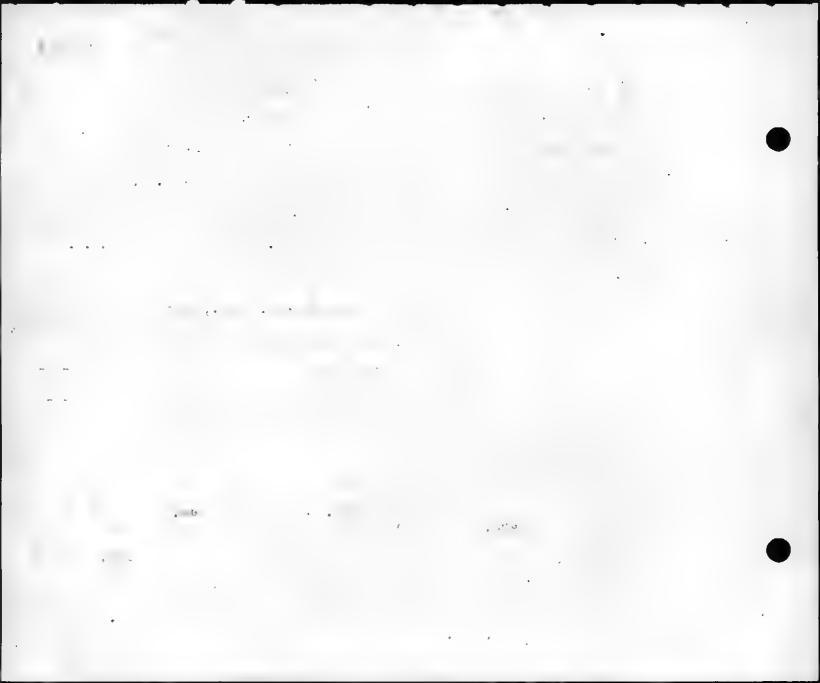


Page 4 may be retained by the nospital of autonomy proposated by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please temove carbon papers. Pages 1 and 2 director, page 3 should be detached for use as the burial-transit permit. Then please temove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and many event, within 72 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR AI5 (4) 20M 1/65 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00544

_	JAVV.								O 10 (D 10)
1.	PLACE OF DEATI	Carroll			-	2. USUAL RESIDENCE a. STATE		If Institution: Re	esidence before admission)
	Sykes	ville		MARY	TAND	Maryland	ш.	COUNTY	
	b. Clay OR TOW	N (if outside corporate tim	its,	c. LENGTH OF STAY		C. CITY OR TOWN (If D	utside corporate limi	ts, write RURAL	and give nearest town)
	Sykes	and give nearest town)				Baltimore		4 429	
		SPITAL OR INSTITUTION (if	not in hos	pital, give street a	ddress)	d. STREET ADDRESS			e. IS RESIDENCE
	Puller	n Nursing Home				1329 Dalt	on Road #3	4	ON A FARM?
3.	NAME OF	First		Middle		Last	4. DATE	Month	Day Year
	(Type or print)	HODA			1100	idek	DEATH Jan	. 5, 196	6 19
5.	SEX	6. COLOR OR RACE 7. M	ARRIED [	NEVER MARRIE	D 🔲 [8	. DATE OF BIRTH	9. AGE (In )		YEAR IF UNDER 24 HRS.
	emale		DOWED 5			ay 24, 1878	H.A	Vrs. Months	Days Hours Min.
10	. USUAL OCCUPAT	ION (Give kind of work done ing life, even if retired)	10b. KIN	D OF BUSINESS OF	l	11. BIRTHPLACE (Cou	nty & State, or foreign o	country)   12. Cl	TIZEN OF WHAT
h	ousewife	ing me, even ii remeu)	ho	me		Czech.			S.A.
	FATHER'S NAM	Ε				14. MOTHER'S MAIDE	N NAME		
F	rank Kore	echy				Unknown			
15	. WAS DECEASED	EVER IN U.S. ARMED FORCES	? 16. 80	CIAL SECURITY NO	17.	INFORMANT	ı	Address	
(11	no, or unkulii)	( If yes give war or dates of servi	1	none	Ma	ry Sikora, d	ght. abov	e	
	18. CAUSE OF	DEATH [Enter only one cau							INTERVAL BETWEEN
		ATH WAS CAUSED BY:			-	canaralized	diabatas		ONSET AND DEATH
	6/ 13	IMMEDIATE CAUSE (a)	Arte	riosciero	BIR	generalized,	ulabetes		
	7 j	DUE TO							11-28-64
	Cenditions, If gave rise to		Gang	rene of 1	ett	toot			11420404
	cause (a), si	tating the DUE TO	_		4 6.				1 5 66
Z	underlying caus			inoma of					1-5-66
T10	PART II. OTHER S	GIGNIFICANT CONDITIONS C	ONTRIBUT	ING TO DEATH BUT N	IOT RELA	FED TO THE TERMINAL DIS	SEASE CONDITION GIV	EN IN PART 1(a)	19. WAS AUTOPSY PERFORMED?
ICA									YES NO
CERTIFICATION	2Da. ACCIDENT OR CONTRIBUTI	WAS UNDERLYING  NG CAUSE OF DEATH OF MEDICAL EXAMINER)	20b. DE	SCRIBE HOW INJU	RY OCCU	RRED. (Enter nature of I	njury in Part I or Par	rt II of Item 18.)	
		INJURY Month, Day, Year	I 2Dd INI	URY OCCURRED	One Diag	E OF INJURY (Home, farr	n,   20f. (City or to	wn) (Cour	ity) (State)
MEDICAL	Hour a.n		While -	Not While		y, street, office bldg., etc		mi) (oou	(Clare)
ME	p.r		at work	at work					,
	21. I certif	y that (I) (this hospital)	attended	the deceased fi	rom No				that (I) (we) last
	saw the dec	peased alive on _ an_	_5	1966, a	nd that	death occurred at 5	$\_{}^{ extsf{A} extsf{M}}$ , from the ca		
	22a. SIGNATU	<i>(</i>	2 -	1/ 20 12					TE SIGNED
	7	town	~ ?	Jall	M.D.	PHYS. UP DI	ED. STAFF	□ Jan.	5, 1966
	22c. PHYSICIA NAME (T)	PE HOWARD	E.	HALL	MD	22d. ADDRESS Sykesyi	lle, Maryl	and	
23a	BURIAL, CREM	ATION, 23b. DATE THER	OF I	23c. NAME OF CE	METERY		23d. LOCATION (C		nty) (State)
B	ur lal (Soe	ation, 23b. Date there 1/8/66		Holy Red	leeme	r Cemetery	Baltimo		
		Tuneral Home,		ADDRESS		25a. REC'	D BY REGISTRAR   25	b. REGISTRAR'S	SIGNATURE
3	331 Brehm	is Lane #13	110-			JAN 1	0 1966	alcorter	0 100
	//	///				PATEN	V 1356 17	- Care and	work.



	DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1	, MARYLAND
	00555 CERTIFICATE OF DEATH	0.0545
1,	PLACE OF DEATH  a. COUNTY Carroll  MARYLAND  2. USUAL RESIDENCE (Where deceased lived, If institution as STATE Maryland b. COUNTY Ba	1to. City
Г	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  c. LENGTH OF STAY IN 1b  c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	and give nearest town)
	Westminster   18 Months   Baltimore City	1
	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  d. STREET ADDRESS	. IS RESIDEN
_	Glover Nursing Home 2623 Cold Spring Lane	YES NO
3	NAME OF First Middle Last 4. DATE Month OF	Day Year
{1	Note The Namie E. Kagler DEATH January	18 1966
	SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years   IF UNDE   lest birthday)   Months	
	Female   Cau.   widowed   Divorced   October 11.1884   81 yrs.	
d	Oe. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHP, ACE (County & State, or fore gn country) 12.	CITIZEN OF WHAT COUN
13	Retired Saleslady Department Store Baltimore, Maryland 3. FATHER'S NAME 14. MOTHER'S MAIDEN NAME	_U.S.A.
	Charles Kagler Mary J.	
15 (Y	5. WAS DECEASED EVER IN U.S. ARMED FORCES?   16. SOCIAL SECURITY NO.   17. INFORMANT Address Yes, no, or unknown)   (Hyes give war or detes of sarvice)	21234
١,	10 I I I I I I I I I I I I I I I I I I I	ngham Ave.
	18. CAUSE OF DEATH (Enter only one cause par line for (a)(b), and (c).)  PART I. DEATH WAS CAUSED BY:	INTERVAL BETWEE
	S 3 / X  Conditions, if any, which governing the underlying cause last.  DUE TO  Could be underlying to the underlying cause last.	
CERTIFICATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTION OF THE TERMINAL DISEASE CONDITION GIVEN IN PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTIONS CON	ART 1(a) 19. WAS AUTO PERFORME YES NO
MEDICAL		County) (Stat
	21. I certify that (I) (this hospital) attended the deceased from Management 1964 to Across 1964	the date stated about 22b. D/SI
	22c. PHYSICIAN'S E Reese WILKENS 15 temper Gesti	muster V
23	33. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, hown or countries)  Burial January 21/66 Mt. Carmel Cemetery Baltimore City	Maryland
24	4 EUNERAL DIRECTOR'S SIGNATURE / ADDRESS 250. REC'D BY REGISTRAR 256. REGISTRAR	'S SIGNATURE
2	Hampstead, Maryland DATE N 3 1966	Pay Judge



6

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. executed within 24 hours after death. THE FIRST TALE RESIDENCE PHYSELAN, The lam remains that the death certificate be Page 4 may be relained by the haspital or attaching physician.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

UHDDb CERTIFICAT	L OF DEATH	1111545					
1. PLACE OF DEATH	2. USUAL RESIDENCE (Where deceased lived, If Institution: Re	sidence before admission)					
a. COUNTY Carroll MARYLAND	a. STATE b. COUNTY						
	Maryland Ment	and also nagget town)					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	c. CITY OR TOWN (If outside corporate limits, write RURAL of	and Rida nearest roun)					
Sykesville I8 Menths	Chevy Chase						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitel, give street address)	d. STREET ADDRESS	e. IS RESIDENCE ON A FARM?					
Springfield St. Hespital	35I5 Tayler street	YES NO					
3. NAME OF First Middle DECEASED	Last 4. DATE Month	Day Year					
(Type or print) George Jeseph Keating	DEATH -	19 66					
	DATE OF DIDTH						
Male White WIDOWED DIVORCED	12~9~05 Age (in year) Months 1	Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR	1 11. BIRTHPLACE (County & State, or foreign country)   12. CIT	IZEN OF WHAT					
during most of working life, even if retired)   INDUSTRY		UNTRY7					
Lawyer	New Yerk U.S	-A-					
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME						
Patrick Keating	Frances Cunningham						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. (Yes, no, or unknown) ((If yes give war or dates of service)	INFORMANT Address						
	Springfield St. Hesp. Records						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	2 Average Services of the serv	INTERVAL BETWEEN					
DADT I DEATH WAS CALLEED DV.		ONSET AND DEATH					
IMMEDIATE CAUSE (a) Heart failure.		days					
4201 DUE TO _							
Conditions, if any, which ) (b) Coronary arterios		years					
gave rise to immediate cause (a), stating the DUE TO Numerous large ga	ngrenous and infected						
underlying cause last. (c) decubitus ulcers	and extreme emaciation.	months					
	TED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	19. WAS AUTOPSY					
E Chyrenic brain syndrome of unknown ca		PERFORMED?					
ÖR CONTRIBUTING   CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	JRRED. (Enter nature of Injury in Pert I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year   20d. INJURY OCCURRED   20o. PLA factor   20m.   20m.	CE OF INJURY (Home, farm,   20f. (City or town) (Cour	nty) (State)					
Hour s.m. While Not While p.m. 19 at work at work	ry, street, office bldg., etc.)						
	7-8- 19 64, to T-9- 19 6	6. that (i) (we) last					
	t death occurred at 35AM, from the causes and on th	e date stated above.					
22a. SIGNATURE		TE SIGNED					
Transper Si Malores M.	DIRECTOR PHYS. X 1-9-	66					
22c. PHYSICIAN'S	22d. ADDRESS						
NAME (Type) Frances Reid Na bors	Sykesville, Maryland	_					
		nty) (State)					
REMOVAL (Specify)							
1-11-66 Burial 1-11-00 Gate of Heaven Cem.   Silver Spring, Md.							
	7 7 1111 4 0 0 0 0						
ROBERT A. PUMPHREY Bethesda, Mar	yland MAN 13 1966 Atherley	udge					

VR AI5 (4) 20M 1/65

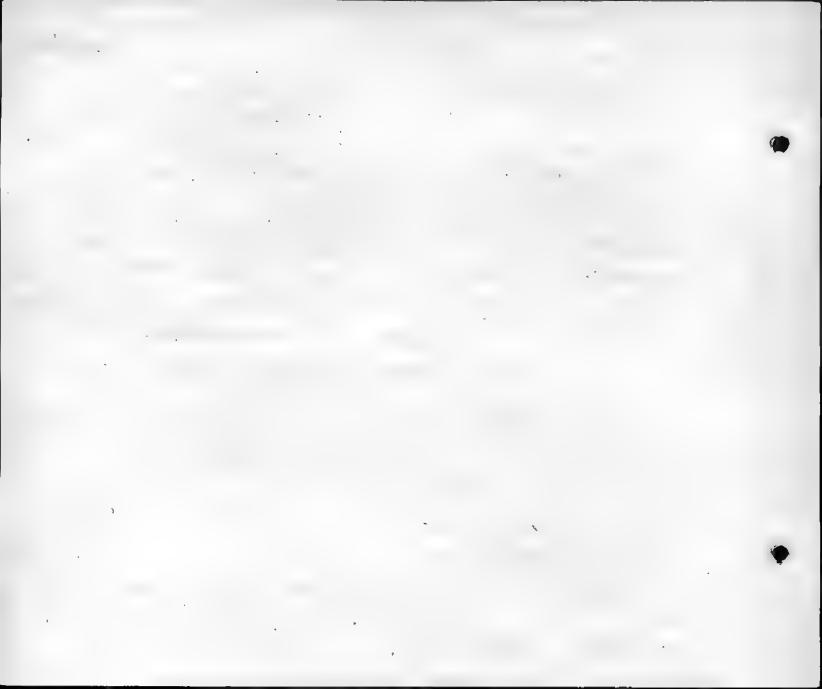


2-12-		Item 18 Film G375 4MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND G0557 CERTIFICATE OF DEATH
wiled in by the funeral Pages 1 and 2 should urs after degits.	1	PLACE OF DEATH a. COUNTY  Carroll  MARYLAND b. CITY OR TOWN (if autside corporate limits, write RURAL end give neerest lown)  Pural Sykesville d. NAME OF HOSTITUTION (if not in hospital, give street address)  2. USUAL RESIDENCE (Where decessed kved, If institution; Residence before edmussion)  a. STATE b. COUNTY  Carroll  C. CITY OR TOWN (if outside corporate limits, write RURAL end give neerest lown)  CARRET ADDRESS  LIFE  A. STREET ADDRESS  LOUNTY  B. COUNTY  A. STREET ADDRESS  LOUNTY  B. COUNTY  A. STREET ADDRESS  LOUNTY  B. COUNTY  A. STREET ADDRESS  LOUNTY  A. STREET ADDRESS  LOUNTY  B. COUNTY  A. STREET ADDRESS  LOUNTY  B. COUNTY  B. COUNTY  CARROLL RESIDENCE (Where decessed kved, If institution; Residence before edmussion)  B. COUNTY  B. COUNTY  CARROLL RESIDENCE (Where decessed kved, If institution; Residence before edmussion)  B. COUNTY  B. COUNTY  CARROLL RESIDENCE (Where decessed kved, If institution; Residence before edmussion)  B. COUNTY  CARROLL RESIDENCE (Where decessed kved, If institution; Residence before edmussion)  B. COUNTY  CARROLL RESIDENCE (Where decessed kved, If institution; Residence before edmussion)  B. COUNTY  CARROLL RESIDENCE (Where decessed kved, If institution; Residence before edmussion)
and completely carbon papers.	S	R.F.D.# 2  NAME OF DECRASED (Type or print)  STERLING D. KNAUFF  SEX  O. COLOR OR RACE   7. MARRIED   8. DATE OF BIRTH  DIVORCED   WIDOWED   DIVORCED   Warch 6 1915   50 yrs.  O. APRINT  VES. NO   19 66  O. APRINT  VES. NO   1
at the death certificate at attending physician (Then please remove cover), and in any event	1	De. USUAL OCCUPATION (Give kind of work lone during most of working life, even if retired)  Farmer  Farming  Carroll Co. Md.  U.S.A.  10b. KIND OF BUSINESS OR INDUSTRY  11. BIRTHPLACE (County & Stele, or foreign country)  Farmer  Farming  Carroll Co. Md.  U.S.A.  14. MOTHER'S MAIDEN NAME  JOHN J. Knauff  Grace A. Keefer  S. WAS DECEASED EVER IN U.S. ARMED FORCES?  16. SOCIAL SECURITY NO. 17. INFORMANT  (17) INFORMANT  Address  Address  NO.   If yes give war or deles of service)   1. Social Security No. 17. INFORMANT  Address  NO.   Information   Informatio
PHYSICIAN: The law requires that the he hospital or attending physician. is certificate has been signed by the atterior use as the burial-transit permit. Then he prior to burial, cremation, or removal,	CERTIFICATION	18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]  PART I. DEATH WAS CAUSED BY.  IMMEDIATE CAUSE (e)  DUE TO  Conditions, if eny, which geve rise to immediate cause [e), stating the underlying cause lest.  DUE TO  Cause lest.
PITAL OR ATTENDING PR Page 4 y be retained by the ERAL DIRECTOR. After this page 3 should be detached fo with the State Dept. of Health	MFPICAL	
TO HOEPITAL  TO HOEPITAL  death. Page 4  to 12 to Y  t		L. E. Robertson   New Windsor, Pad.  Sa. BURIAL, CREMATION, 23b. DATE THEREOF   23c. NAME OF CEMETERY OR CREMATORY   23d. LOCATION (City, Iown or county)    REMOVAL (Specify)   Jan. 22 1966   Sams Creek Brethren   Carroll Co. Nd.  FUNERAL DIRECTOR'S SIGNATURE   ADDRESS   25b. REGISTRAR'S SIGNATURE    C. N. Waltz Box 241 Sykesville, Pad.   Carroll Co. Nd.    C. N



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MARYLAND CERTIFICATE OF DEATH funeral 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) 1. PLACE OF DEATH e. COUNTY b. COUNTY 출<u>구</u>축 MARYLAND NrHOI c. CITY OR TOWN (If outside corporate limits, write RURAL end give neares) b. CITY OF TOWN (if outside corporate limits, E. LENGTH OF STAY IN 16 IS RESIDENCE ON A FARM? YES NO DE complete, Day 3. NAME OF OF DECEASED DEATH (Type or print) 19 AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. 5 SEX MARRIED NEVER MARRIED and lest berthday) Months Days WIDOWED DIVORCED physician 12. CITIZEN OF WHAT COUNTRY? USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY done during most of working life, even if retired) FATHER'S NAME ARMED FORCES? 16. SOCIAL SECURITY NO.1 (Yes, no, or unkown) | (Ifyes give wer or dates of service) 7-28 18. CAUSE OF DEATH [Enter only one cause per-time for (e), (b), and (c) à ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) DUE TO gave rise to immediate cause DUE TO (a), sleting the underlying PART IL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1.611 19. WAS AUTOPSY PERFORMED? YES NO DO 20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18) CERTIFI 20a ACC DENT WAS UNDERLYING TO (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY , Home, farm, 20f. (City or town) (County) (Stete) 20d. INJURY OCCURRED 20c. TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) While Not While Hour a.m. et work at more p.m. certify that (I) (this hospital) attended the deceased from ... 7-4 -19.6.7 to 1 = 4 ...... 19.6.4 that (1) (we) last saw the deceased alive on . 22a SIGNATUR ATTENDING SIGNED PHYS. DIRECTOR FUNERAL 22d. ADDRESS 22c PHYSIG director, be filed 23d, LOCATION (City, town or county) (State) NAME OF CEMETERY OR CREMATORY BURIAL, CREMATION 0 H Evergreen Mem. Gardens Finksburg MD. REC'D BY REGISTRAR 256, REGISTRAR'S SIGNATURE VR A15 ,41 24 FUNERAL DIRECTOR'S SIGNATURE 15M 7 61 Tipton-Eline Hampstead. Md.

BYLAND STATE DEPARTMENT OF HEALTH



TO HOSPITAL OR ATTENDING PHYSICIAN: The law remaires that the death certificate by executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tarbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in a the complex within 72 hours after deaph.

> VR #15 (4) 20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

OF STATISTICAL RESEARCH AND RECORDS AND ADMINISTRATION OF STATISTICAL RESEARCH AND RESEARC

	00559			CERTIFIC	AII	E OF DEATH	1			1111	544	
1.	PLACE OF DEAT	4				2. USUAL RESIDENC	CE (Where d	deceased lived,	f institution:	Residence	before ad	mission)
	a. COUNTY Carroll MARYLAND					a. STATE	3	b. (	COUNTY			
<u> </u>			h = 1114-	MARYL		c. City OR TOWN (If		-ma-sta Herit	welle DIID	At and all	10 DOSTOR	+ +own)
	write RURAL	N (if outside corpora and give nearest tow	re iimits, j	C. LENGTH OF STAY	IN 1D	C. CITY OR TOWN (IT	outside co	othotare muit	s, write ROR	WE and Re	ve licales	Liberty
	Elder	sburg				Baltir	nore			7		
				spital, give street ad	dress)	d. STREET AOORESS					. IS RES	IDENCE ARM?
_		ty and Okla	homa ko	ads		2308 S	idney		21230			NO 🗌
3.	NAME OF DECEASED	Fi	rst	Middle	_	Last	4. DATE	E N	Aon th	Oay	Yea	r
	(Type or print)		narles	R.		Leutner	DEAT	и Jan	5, 196	6	19	
5.	SEX	6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	V 1	B. DATE OF BIRTH		9. AGE (In ye	ars   IF UND			
	Male	White	WIDOWED	OLVORGED		Oct. 7, 188	88	last birtho	1110111211	Oays	Hours	Min.
10a	USUAL OCCUPAT	ION (Give kind of work	done 10b. Ki	ND OF BUSINESS OR		11. BIRT HPLACE (C				CITIZEN	OF WHAT	-
dur	ing most of work Clerk	ing life, even if retire	d) Hard	DUSTRY lware Store		Baltimore	Mar	be e for		COUNTRY	· ·	
13.	FATHER'S NAM	Ē	11002	111010 0010		14. MOTHER'S MAIC		y La IN				
		Leutner				Pauline						
9 6		EVER IN U.S. ARMED FO	PCCC2   16	SOCIAL SECURITYNO.	1 17	INFORMANT		0.4	delener a			
	s, no, or unkown)	(If yes pive war or dates o	f service)			•			odessSid			
	No	None	ST3	3-14-3588	Mr.	Richard F.	Leutr	ner Ba	ltimor	e. Mc	1. 3	0
	18. CAUSE DF	DEATH [Enter only on	e cause per li	ne for (a), (b), and (c).	j					INTE	RVAL BE	WEEN
H	PART I. DI	ATH WAS CAUSED BY	1	Perminal I	Dinty:	omonia				UNS	ET AND C	YEATH YES
H	011	IMMEDIATE CAUSE	(4)									-
Conditions, if any, which by Shronic Heart Falure							t <sub>t we</sub>	1-0				
	gave rise to	immediate	(-,	elii Vili "G. a-C	<u> </u>	o railuic					1 00	<u>Lambel</u>
	cause (a), s			\ t	.m =	~					7	
2	underlying caus			<u>ulminary</u>		TEO TO THE TERMINAL (	DICEAGE OF	MINITIONICINE	M INDART 1/	a) 119.	WAS AU	TOPSY
ATI	PART II. OTHER			t selects			01317431.00	ALDITION GIVE	31 111 1111 21		PERFOR	MED?
2		P D	//				£ 3	Death Las David	tt of them	YE	.s [	NO V
CERTIFICATION	OR CONTRIBUTI (IF EITHER, NO	WAS UNDERLYING ☐ ING ☐ CAUSE OF DEA TIFY MEDICAL EXAMI	TH NER)	F2CKIRE HOM INJUK	- OGGU	RRED. (Enter nature of	T INJULY IN	Part I of Part	ii or item	10.)		
동	20c. TIME OF	INJURY Month, Day,	Year   20d. If	JURY OCCURRED   20		CE OF INJURY (Home, fa		(City or tow	n) (C	ounty)	(\$	tate)
MEDICAL	Hour a.s		While at work	Not While	tacto	ry, street, office bldg., e	etc.j					
2				d the deceased fro	om_)	ec.231	9.65., to	o Dec	3,119.	25., tr	at (!) (v	/e) last
		ceased alive on	Jan 5	19 66 an	d that	death occurred at	2	from the cau	ises and on			above.
	22a. SIGNATU	RE	6.	/		ATTENOING -	MEO.		22b.	DATE SI	GNED	
		Sam o	Gung	man	M.0	PHYS.	DIRECTOR	STAFF PHYS.		1///	56.	
	NAME (T	/mal	A. Oku	itman, M.	D.	Obrec	cht R	d. Syl	cesvi.	lle,	Md.	
23a	. BURIAL, CREM	IATION, 23b. DATE		23c. NAME OF CEN	METERY	OR CREMATORY	23d.	LOCATION (Ci	ty, town or	county)	(St	ate)
	REMOVAL (Sp. Burial	1/8/196		London P	a rk	Cemetery	D-	1+imon	5.14			
24	. FUNERAL DIRI			ADDRESS / -	A.	1_25a. RE	C'D BY REC	altimor	. REGISTR	AR'S SIGN	ATURE	
1	1. 1 -	1 - 1	. 0	Ball	19.1	mg.17	JAN 8	196	G 800	iarl	2 0	das
1/1	mary	uhme	1-20	no houts	Led	- 1-a-delle	יחוו ע		0 /	7 (4	V	1



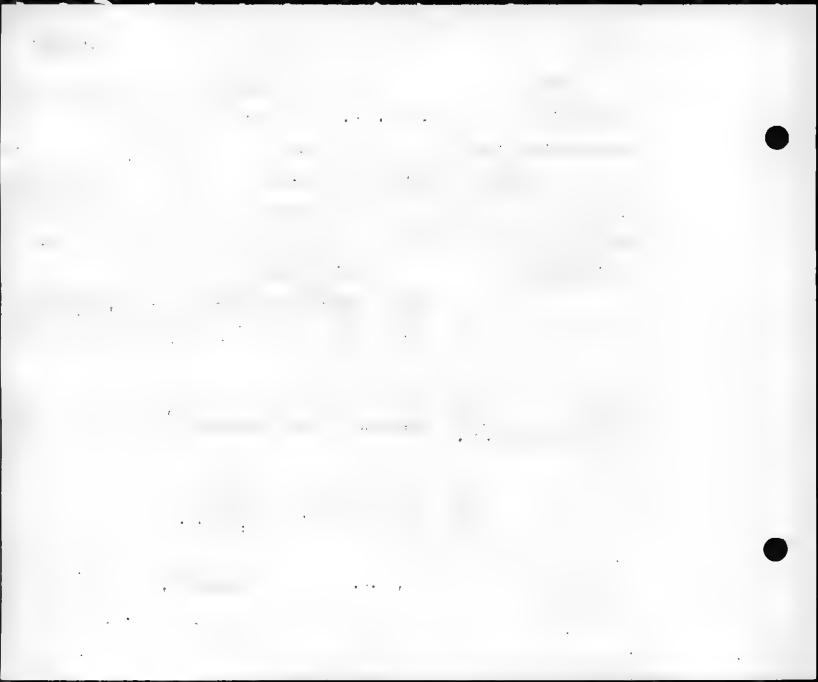
TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after meath. THE HOSPITAL BY ATTENDING PHYLICIAN: The lam requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00560 CERTIFICATE OF DEATH

J.	a. COUNTY	1				NCE (Where deceased		tion: Residence	before admission)
Carroll MARYLAND				a. STATE Ma	ryland	b. COUNTY	Washi	ngton	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				If outside corporat	e limits, write i	RURAL and giv	re nearest town)		
Ru	ralSyk	esville	YII)	6y. 11m. 1d.	Boonesbo	ro	- 1	7	
			ON (if not in ho	ospital, give street address)	d. STREET AOORES			8	. IS RESIDENCE
S	pringfie	ld State	Hospita	ıl	Route #2			Y	ON A FARM?
3.	NAME DF DECEASED	F	Irst	Middle	Last	4. DATE	Month	Oay	Year
	(Type or print)	Ca	rrie	Edith	Martz	DEATH	1	18	19 66
5.	SEX	6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	8. OATE OF BIRTH	9. AGI			IF UNDER 24 HRS.
1	emale	white	WIDOWEO	OIVORCED	4/8/92	73	yrs.	nths Days	Hours Min.
10	a. USUAL OCCUPAT	IDN (Give kind of working life, even If retire	done 10b. Ki	ND DF BUSINESS OR	11. BIRTHPLACE	County & State, or fo	reign country)	12. CITIZEN COUNTRY	OF WHAT
"	housewi	.fe		IN COUNTY	Maryla	nd		ODOMIKI	USA _
13	FATHER'S NAM	E			14. MDTHER'S MA				
	Franklin	Bowers		Jenn	e Sumam				
		VER IN U.S. ARMED FO			INFORMANT		Address		
1,,	no	(11 yes give that or nates)	) service)	none Sp	ringfield	Hospital	record	s, Syke	esville
	18. CAUSE OF	DEATH [Enter only on	ne cause per li	ne for (a), (b), and (c). ]	ardios.	rapert	JUL VAI	LUKATE	RVAL BETWEEN ET AND DEATH
Н	PART I. OF	ATH WAS CAUSED BY IMMEDIATE CAUSE	->1/	VVOCAROLL	AL In	TARCT	Ton	UNS	EI AND DEATH
	tal oue to 1/2								
	Conditions, If any, which (b) 6 Search 174,								
	gave rise to cause (a), si				-1				
	underlying caus	aring the	(c)						
NO.	PART II. OTHER S	IGNIFICANTOONOITI	ONSCONTRIBU	TING TO DEATH BUT NOT RELI	TED TO THE TERMINA	L DISEASE CONDITIO	N GIVEN IN PAR	T1(a) 19.	WAS AUTOPSY PERFORMED?
CERTIFICATION	Chronic	brain sy	ndrome	of unknown o	r unspecif	ied cause	with	YES	
	20a. ACCIDENT	WAS UNDERLYING	2Db. 0	ESCRIBE HOW INJURY OCCU	JRREO. (Enter nature	of Injury In Part I	or Part II of It	em 18.)	
CER	(IF EITHER, NO	hotic read Was underlying NG CAUSE OF DEA IFY MEDICAL EXAMI	NER)						
GAL S	2Dc. TIME OF	NJURY Month, Day,	*		CE DF INJURY (Home,		or town)	(County)	(State)
MEDICAL	Hour a.o		While at work	- NOT MULIE	ry, street, office bldg.	,etc.)			
≥				d the deceased from	2/17/	1959 to	1/18/	1966 th	at OK (we) last
		ceased alive on.	1/18		t death occurred at				
	22a. SIGNATUS		1	A A	C GCGCII DOGGII CG GC	The state of the s		Zb. OATE SIG	
	TIG	11. Tale	Crolx	Testal M.	ATTENOING D	MEO. OIRECTOR TO	HYS.	1//	8166
	22c. PHYSICIA			77		Springfie	ld Sta	te /Hos	oital
	NAME (T)	pe) Fausto	Acosta	Natal, M.D.		Sykesvill	e. Mar	yland_	
23	a. BURIAL, CREM	ATION, 23b. DATE	THEREOF	23c. NAME OF CEMETER	OR CREMATORY	23d. LOCATI	ON (City, town	or county)	(State)
	REMOVAL (Spe	city)	2n. Lh	(d) omisine	a santhy	The sa	mun XI	co !	:14
24	L TUNERAL OIRE			AOORESS		EC'O BY REGISTRA		STRAR'S SIGNA	ATURE
1	Datte	y Vouce	Talix	( Bax 1 )	BOUSE, DATEA	N 2 4 196	a police	mela, O.	edge
			The Address of	11 6 / ( 2 2 ) . / - 1		4 /4 7 14 14		- V . 72.	

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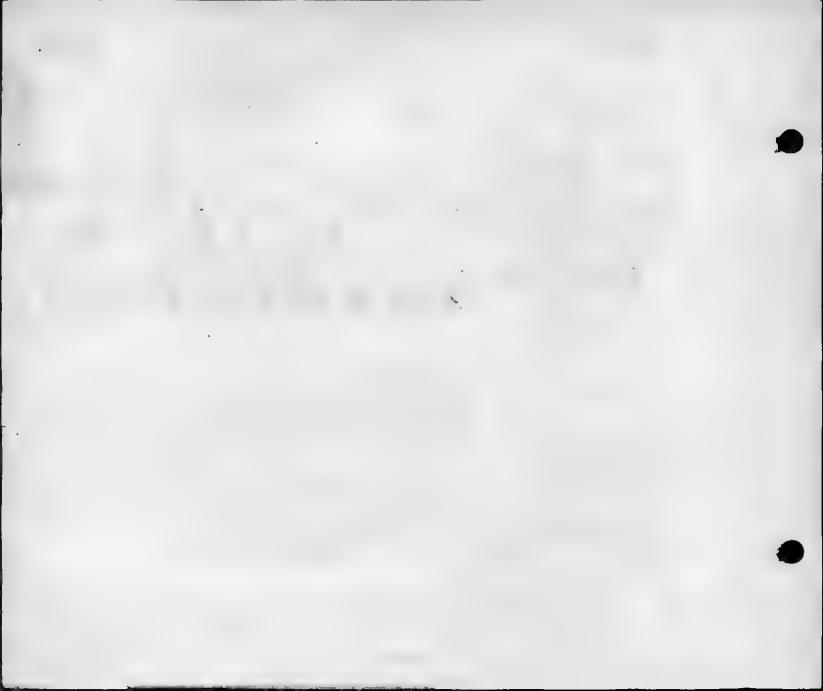
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2	1		MARYLAND STATE DEPARTMENT OF HEALTH  DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARY	LAND
.4	= 72	5	00561 CERTIFICATE OF DEATH	551
The state of the s	e funeral 1 and 2 ter death:		PLACE OF DEATH  a. COUNTY Carroll  MARYLAND  2. USUAL RESIDENCE (Where deceased lived, If institution: Residence as STATE b. COUNTY  MARYLAND  Maryland  Baltimore	
4	and completely filled in by the femore carbon papers. Pages 1 anyevent, within 72 hours after		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  MARYLAND  Maryland  C. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	ive nearest town)
	d in	-	Sykesville Syrs.7mos.7dys. Baltimore 3 . / d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS	e. IS RESIDENCE ON A FARM?
		2		YES NO 🗙
100 mg	rbon , wit	3.	DECEASED	
7	sent sent	5.	(Type or print) IRVIN JOSEPH McCURRY DEATH JANUARY 21  SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR	19 66 RUFUNDER 24 HRS.
1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	The state of the s		Male White WIDOWED DIVORCED 4-16-11 54 yrs.	
	D	1D du	Da. USUAL OCCUPATION (Give kind of work done in Db. KIND OF BUSINESS OR II. BIRTHPLACE (County & State, or fereign country) 12. CITIZEN COUNTRY	Y7
4	hysic plea al, ar	13	Name Painter Maryland U.S. 3. FATHER'S NAME 14. MOTHER'S MAIDEN NAME	Α.
2	attending phy ermit. Then p nn, or removal,		John A. McCurry Mary L. Cullen	
	tendi iit.	15 (Y	5. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address Yes, no, or unknown) (If yes give war or dates of service) None Records. Springfield State Hosp	
4	the at t perm ration,	_		ital ERVAL BETWEEN
1	intes that one usaut of physician. It is signed by the attencharial-transit permit. It burial, cremation, or it is burial.		DART I REATU WAS CAUSED DV.	SET AND DEATH
4	ysici ysici igne rial-tı rial,		+90 X DUE TO	
	e bull		Conditions, if any, which gave rise to immediate but to bu	
	aw required the state of the st		underlying cause last. (c)	
ī	In the first rive law requires that the heads cellulidate be oppital or attending physician.  certificate has been signed by the attending physician hed for use as the burial-transit permit. Then please to fleating prior to berial, cremation, or removal, and in	CERTIFICATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)  Schizophrenic reaction, simple type	PERFORMED?
	notani ospital certific thed for it, of He	CERTIF	2Da. ACCIDENT WAS UNDERLYING   20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury In Part I or Part II of Item 18.)  OR CONTRIBUTING   CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
	d by the host After this ce d be detached	MEDICAL	2DC. TIME OF INJURY Month, Day, Year 2Dd. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  P.m. 19 at work at work at work	(State)
	retained by cetained by CTOR: After should be wit I I I E Stain	-	21. I certify that (1) (this hospital) attended the deceased from 6-11-35 19 to 1-21-66, 19 t	that (I) (we) last
	ctair ctair cton shor		saw the deceased alive on 1-21-66 19 , and that death occurred at 2.3 M, from the causes and on the date of the causes are caused at the causes and on the date of the causes are caused at the causes and on the date of the causes are caused at the cause of the cause of the caused at the cause of the	
	Page 4 may be retained by the hospital or attending physician. To FUNERAL DIRECTOR. After this certificate has been signed by director, page 3 should be detached for use as the burial-trans should be filed wiff the State mept.		Frances Red Nabora M.D. ATTENDING MED. STAFF DIRECTOR PHYS. Star J	1.1966
	ctor,		NAME (Type) Frances Reid Nabors, M. D. Sykesville, Maryland	
1	Page 15 Figure 1		Burial (specify)  1-24-66  Date Thereof Loudon Ports Compton (City, town or county)  Burial (Specify)  1-24-66  Loudon Ports Compton (City, town or county)  Baltimore, Md.	(State)
	-	2 I_	Burrar   1-24-66   Loudon Park Cometers   Battimore, Md.	NATURE
		4		

...... *t* .

. 1	MARYLAND STATE DEPARTMENT OF HEALTH
2	DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
aral uid,	00562 CERTIFICATE OF DEATH00552
hours after the funeral od Z should	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission a. STATE ) b. COUNTY 1
hour the saft.	Carroll MARYLAND RANSILVANIA VOIL
24 clar	b. CITY OR TOWN (if outside corporete limits, write RURAL and give nearest lown)  write RURAL and give nearest lown)
in bed i best in a set in a se	Manchester 2/8/15 New treedom  d. NAME OF HOSPITAL OR INSTITUTION LIFT not in hospital, give sivest address)  d. STREET ADDRESS  d. STREET ADDRESS  e. IS RESIDENCE
	Long View Nuising Home Inc W. Franklin St YES NOW
executed completely on papers.	3. NAME OF DECEASED OF Month Day Year
o exected compared co	(Type or print) // Namee, Cleveland Hda DEATH Jan 26 1966
8 Þ.€.≱	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. lest birthday) Months Days Hours   Min.
ficate   cian ar ove ca event,	temale White WIDOWED & DIVORCED Jan 16, 1883 81 mm.
certificate physician a s remove c	done during most of working life, even if retired)
_ O _	House wife Daltimore (6 Mayland) USH
a eigh	Frank P Gove Mary E Gove
	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT  (Yes, no, or unkown) (Hypergiveweror dates of sarvice)
s that the an. y the atte mit. Ther removal,	No 19 1362634 Mis Helen Hedrick Wew Heldom, 4.
The law requires that the tending physician. s been signed by the attervirel-transit permit. There is cremation, or removal,	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), end (c).]  PART I, DEATH WAS CAUSED BY:
he law requires anding physicial been signed by rrial-transit perm cremation, or r	MMEDIATE CAUSE (a) If it is to more to make and to the contraction of
e law requading phy nding phy sen signe ial-transit	Due to 2) Dealetes melletus - 5ing
The law requateding phy as been signe burial-transitial, cremation	Conditions, if any, which (b) gave rise to immediate course DUE TO
9 2 2 9	(e), stating the undarlying causa lest.
PHYSICIAN: the hompital or nis certificate to for use as the th prior to but	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?
PHYSICIA the hompital his certificat I for use as lifth prior to	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II.S  PREFORMED?  YES NO   YES NO   OR CONTRIBUTING CAUSE OF DEATH  III. EITHER, NOTHER JUNG CAUSE OF DEATH  III. EITHER, NOTHER MEDICAL EXAMINER;
PHY the this c for th pu	20a. ACCIDENT WAS UNDERLYING ☐ 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
F F F F F F F F F F F F F F F F F F F	IF EITHER, NOTIFY MEDICAL EXAMINER)
NDING I ined by the the After the defacted to of Health	Abur e.m. Whila Not Whila
E 5025	21. I certify that (1) (this hospital) attended the deceased from 11-4-, 1964 to 16-, 1966, that (1) (we) last
OR A1 lay be IREC: should State I	saw the deceased alive on 1966, and that death occurred at 30/M, from the causes and on the date stated above.
	226. SIGNATURE ATTENDING MED. STAFF 22b. DATE SIGNED
PITAL Fegs 4 ERAL Page with th	M.D. PHYS. DIRECTOR PHYS.
TO HOSPITAL  Seath. Figst 4  TO FUNERAL  director, page be filed with it	22e. PHYSICIAN'S NAME (Typa) W. H. FUTHULO P. 22d. ADDRESS 1/ALL LOTTE AND 1/26/6
O HOSP Besth. T O FUNE director, be filed v	230. BURIAL, CREMATION, 23b, DATE THEREOF 23c, NAME OF CEMETERY OR CREMATORY (State)
H H	LOTITI al Van 27. / 166/16W/reedom Cemeleix/Vew/reedom./ennd
VR A15 (4)	24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS PAGESTRAR'S SIGNATURE TO THE STATE OF THE S
20M 5-63	Harrington, Mew Sitillown, Vev, Date



MARYLAND STATE DEPARTMENT OF HEALTH



	MARYLAND STATE DEPARTN	MENT OF HEALTH	
DIVISION OF STATISTICAL	RESEARCH AND RECORDS, 301 W	. PRESTON STREET,	BALTIMORE 1, MARYLAND
70 to 20 20	CEDTIFICATE OF	DEATH	0.0554

١	nassa ce	RTIFICATE OF DEATH	80554
	1. PLACE OF DEATH		lived, if Institution: Residence before admission)
	a. COUNTY	a. STATE	b. COUNTY CORROLL
	b. CITY OR TOWN (If outside corporate limits,   c. LENGTI	MARYLAND H OF STAY IN 1b C. CITY OR TOWN (II/outside corporate	limits, write RURAL and give nearest town)
	write RURAL and give nearest town)	Mrn Lind t	1 A-#2
	uestrumeter.	Mestmuester	e. IS RESIDENCE
1	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give	e street address) d. STREET ADDRESS	ON A FARM?
1	Carroll Comby Heller	Fropeles Misson Brine	YES WO
ı	3. NAME DF First N	fiddle Last 4. DATE	Month Day Year
1	(Type or print) HARRY PAU	L MURELOCK DEATH -/	ANURARY 30 1966
	5. SEX   6. COLOR OR RACE   7. MARRIED   NEVER	MARRIED   8. DATE OF BIRTH   9. AGE	(in years   IF UNOER 1 YEAR   IF UNDER 24 HRS.
	male_ White WIDOWED	DIVORCED   May 16 1893 19	birthday) Months Days Hours Min.
	102. USUAL OCCUPATION (Give kind of work done) 10b. KINO OF BUS	DITOROLD	eign country) 12, CITIZEN OF WHAT
1	during prost of working life, even if retired) INDUSTRY		COUNTRY?
1	famer -	Curroll Co. m.	asylone Misia.
1	13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	Let 1
1	sucob a mouloch	helyafeth Bug	gara
	15/WAS OECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SEC (Yes/no, or unknown)   (If yes give war or dates of service)	CURITY NO. 17. INFORMANT	Address
1	(1egrat, or discount) ((1. yes give mar or dates or service)	Mars Ruth R. morel	och Jane
	1 18. CAUSE OF DEATH (Enter only one cause per line for (a).	(b), and (c), ]	INTERVAL BETWEEN
	PART I. DEATH WAS CAUSED BY:	STALL AL	ONSET AND GEATH
	IMMEDIATE CAUSE (8)	and the	
	T L T DUE TO		
	Conditions, if any, which gave rise to immediate (b)	rigativerous	
	cause (a), stating the DUE TO		
	underlying cause last. (c)		
	PARTIL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DE  20a. ACCIDENT WAS UNDERLYING   20b. DESCRIBE F  OR CONTRIBUTING   CAUSE OF DEATH  (IF EITHER, NOTIFY MEDICAL EXAMINER)	ATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITIO	NGIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED?
	N N N N N N N N N N N N N N N N N N N		YES _ NO Z
	20a, ACCIDENT WAS UNDERLYING 20b. DESCRIBE I	HOW INJURY OCCURRED, (Enter nature of injury in Part 1 of	or Part II of Item 18-)
	OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		
	20c. TIME OF INJURY Month, Day, Year   20d. INJURY OCC	URRED   20e. PLACE OF INJURY (Home, farm,   20f. (City	or town) (County) (State)
	20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCC Hour a.m. While at work 19 at work 12 at work 19 at work		
			2 2 2 del . 11 10 10 10 1 dest
	21. I certify that (1) (this hospital) attended the de	ceased from Man, 1960, to	196(n, that (1) (we) last
	saw the deceased alive on 22a, SIGNATURE 22a, SIGNATURE	and that death occurred at M, from the	e causes and on the date stated above.
	22a. SIGNATURE		TAFF 1 Fal 1 167/
	Cheese was		HYS. 1 1-66-11766
	22c. PHYSICIAN'S NAME (Type) - POGGO	22d. ADDRESS	* *
	P.MESE WILL		
	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NA	AME OF CEMETERY OR CREMATORY 23d. LOCATI	ON (City, town or county) (State)
	Bureal 4/3/00 11/	udora Cemelery Kural,	Westminder md.
1	24. SUNERAL DIRECTOR ADI	DRESS 25a. RIC'D BY REGISTRAL	250/ REGISTRARIS SIGNATURE
1	1 his Monalm h / hatreen	ter, ml. FEB'3 1966	1

VR A15 (4) 15M 4-64



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE, OF DEATH funeral PLACE OF DEATH a. COUNTY a. STATE filled in by the fu papers. Pages 1 Maryland Carroll MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b sician and completely filled in by lease remove carbon papers. Pag and in any event, within 72 hours Baltimore 40yrs.10mos.9dys vkesville d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS Springfield State Hospital (Bay View 3. NAME DE First Middle 4. DATE oderacz Last DECEASED MORGAN **ODENSAUS** DEATH (Type or print) ALICE 6. COLOR OR RACE DATE OF BIRTH 7. MARRIED X NEVER MARRIED White Female 85 DIVORCED 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY attending physician rmit. Then please r Maryland none FATHER'S NAME 14. MOTHER'S MAIDEN NAME remova unknown Charles Morgan
15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, mo, or unknown) | (If yes give war or dates of service) been signed by the attendithe burial transit permit. 17. INFORMANT 16. SOCIAL SECURITY NO. Records, Springfield State Hospital (none) no 18. CAUSE DF DEATH | Enter only one cause per line for (a), (b), and (c), ] Coronary occlusion PART I. DEATH WAS CAUSED BY: OR ATTENDING PHYSICIAN: The Grant requires That the retained by the hospital or attending physician. IMMEDIATE CAUSE (a DUE TO Conditions, if any, which (b) gave rise to immediate this certificate has been detached for use as the beat, of Health prior to DUE TO (a), stating the underlying cause last CERTIFICATION Schizophrenic reaction plus mental retardation 20a. ACCIDENT WAS UNDERLYING CONTRIBUTING CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) FUNERAL DIRECTOR: After this certificator, page 3 should be detached includ be filed with the State Dept. of MEDICAL 20f. (City or town) 20d. INJURY OCCURRED 120e, PLACE OF INJURY (Home, farm, TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) Hour a.m. Not While While at work at work 21. I certify that th (this hospital) attended the deceased from March to Jan. 19 66 saw the deceased alive on Jan. 22a. SIGNATURE ATTENDING PHYS. TO HOSPITAL O Page 4 may b M.D. ADDRESS 22d. PHYSICIAN'S director, p NAME (Type) Sykesville. Md. Ilse Kamm. M.D. BURIAL, CREMATION, REMOVAL (Specify) LOCATION (City, town or county) 23c. NAME OF CEMETERY OR CREMATORY DATE THEREOF 2 REC'D BY REGISTRAR I 24. FUNERAL DIRECTOR

VR A15 (4) 15M 4-64

Mours after death.

executed

certificate be

eat

WAS AUTOPSY

PERFORMED?

YES I

NO X

(State)

(State)

USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) b. COUNTY

altimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

e. IS RESIDENCE ON A FARM?

NO X YES Month Year 1966 JANUARY

AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. last birthday) Months Days Hours

12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) COUNTRY? U.S.A.

Address

INTERVAL BETWEEN ONSET AND DEATH Arteriosclerotic cardiovascular disease years

MARYLAND STATE DEPARTMENT OF HEALTH

PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of Injury in Part I or Part II of Item 18.)

(County)

21 66 that (i) (we) last

and that death occurred at 1:45 M. Them the causes and on the date stated above. 22b. DATE SIGNED

Jan. 21, 1966

25b. REGISTRAR'S SIGNATURE





MARYLAND STATE DEPARTMENT OF HEALTH



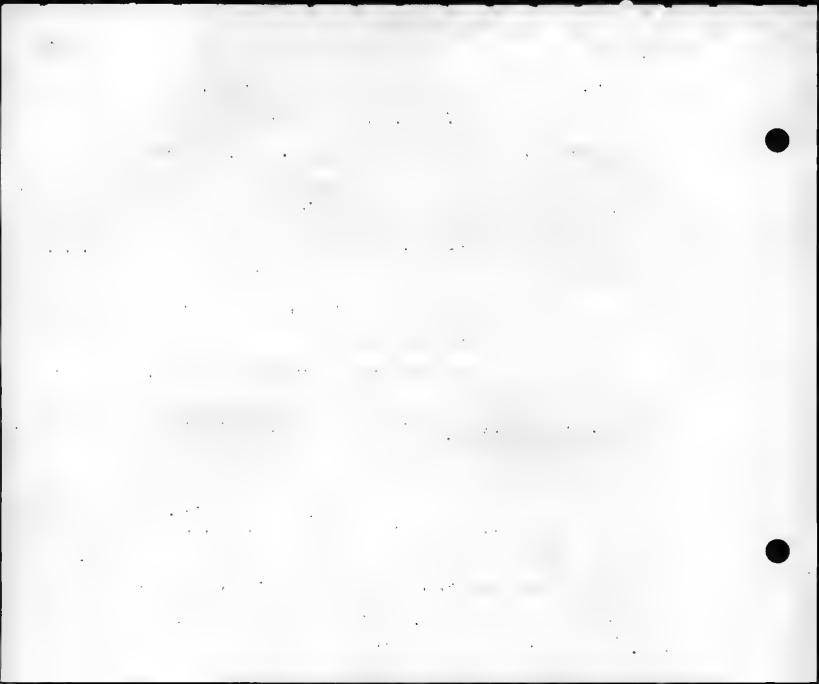
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit mermit. Then please remove carbon papers. Pages I and Should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after dept.

TO NUMBITAL OR ATTEMBRIC PRYSICAN: The law requirms that the death cartificate Ba exacuted with 24 hours after death. Page 4 may be retained by the hospital or attending physicalm.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

	_	UUJOJ GERTIFICA	HE UF DEATH	UU008						
Н	1.	PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived, If institution: R	esidence before admission)						
		G33	a. STATE Maryland b. COUNTY Wa	ahinatan						
1	_	CATFOLL MARYLAND  C. LENGTH OF STAY IN 1  write RURAL and give nearest town)	Maryland Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest tow							
-				3						
١		Sykesville 4yrs, 10mos, 1day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address	Hagerstown /- ss) d. STREET ADDRESS	e. IS RESIDENCE						
I		G. HAME OF HOSPITAL OR HISTITOTION (II not in nuspital, give streat address	d. SIREET ADDRESS	ON A FARM?						
		Springfield State Hospital	143 W. Franklin Street	YES NO X						
	3.	NAME DF First Middle DECEASED	Last 4. DATE Month	Day Year						
		(Type or print) HELEN MARY	RAMSEY DEATH JANUARY	18 1966						
- [	5.	SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED	8. DATE OF BIRTH 9. AGE (In years   IF UNDER							
1	F	emale White WIDOWED Y DIVORCED	3-23-90 (ast-olrthday) Months	Days Hours Min.						
	10a duri	USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR Ing most of working life, even if retired)	11. BIRTHPLACE (County & State, or foreign country)   12. C	TIZEN OF WHAT						
		Nurse Marsing	Pennsylvania	U.S.A.						
1	13.	FATHER'S NAME	14. MOTHER'S MAIDEN NAME							
Į		(unknown)	(unknown)							
1	15.	S. An. or unknown) ((fives nive war or dates of service))	7. INFORMANT Address							
1		None I	Records, Springfield State Hos	spital						
1	1	18. CAUSE DF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN						
1	-1	PART I. DEATH WAS CAUSED BY: Bronchopneumonia ONSET AND a We								
-	- 1	1221 DUE TO		-						
ı										
	gave rise to immediate (ii). All del la del									
		undarlyle enver lest								
	8	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOTR	FLATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	19. WAS AUTOPSY						
	Ā	Chronic Brain Syndrome associated	with senile brain disease	PERFORMED?						
1	ᆲ	Chronic Brain Syndrome associated with psychotic reaction.  20a. ACCIDENT WAS UNDERLYING     20b. DESCRIBE HOW INJURY OF	CCURRED. (Enter nature of injury in Part I or Part II of Item 18.	YES NO X						
	CERTIFICATION	OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	COOKER. (Enter nature or injury in Part 1 or Part II or item to	•)						
	R	20c. TIME OF INJURY Month, Day, Year   20d. INJURY OCCURRED   20e. I		nty) (State)						
1	MEDICAL	White Could while while	ctory, street, office bldg., etc.)							
1	Σ	p.m. 19 at work at work	March 17 1960 to Jan. 18 19 6	5 u 1965 t 1 194						
1	ı	21. I certify that-(I) (this hospital) attended the deceased from.	naten 17, 1900, 10 vans 10, 19 c	6, that (1) (we) last						
1		saw the deceased alive on Jan. 18 1966, and t	hat death occurred a2:50 MAssorn the causes and on the	ATE SIGNED						
J		W	ATTEMPING MED STATE	8-66						
	- 1	22c. PHYSICIAN'S	M.D. PHYS. DIRECTOR PHYS. X 1-1  22d. ADDRESS	0-00						
	i	NAME (Type) Ilse Kamm, M.D.	Sykesville, Maryland							
	23a		ERY OR GREMATORY 23d. LOCATION (City, town or col	inty) (State)						
		Bruing 1-21-66 At 72	EUS 1 TRIBETUR TWO	PA.						
	24.		25a. REC'D BY REGISTRAR 25b. REGISTRAR	S SIGNATURE						
	1	est, 3 Ff. Hallfly Chyfelully	med pate 1 20 1996 Cliente	a Quelas						
9	900	//	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	A STATE OF THE STA						

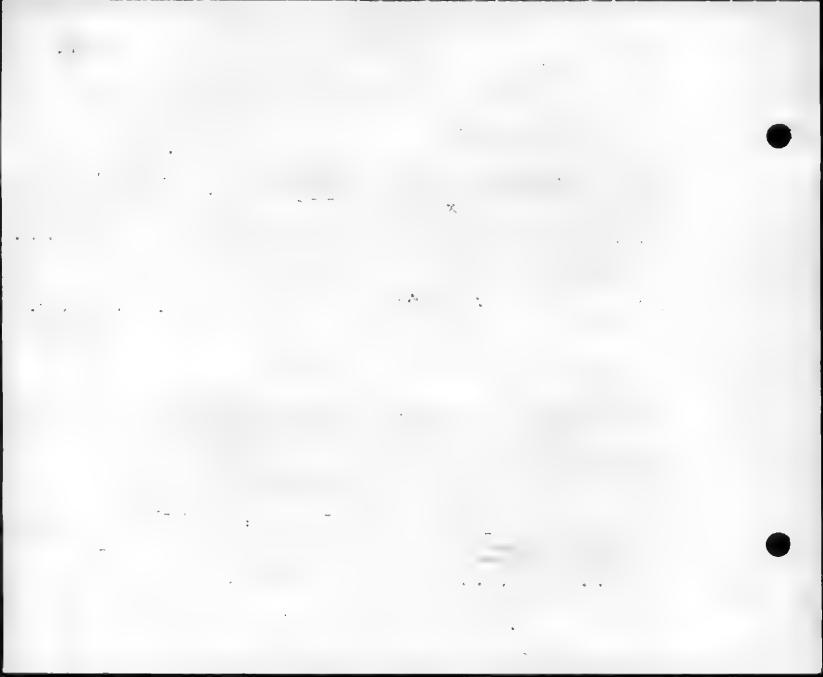
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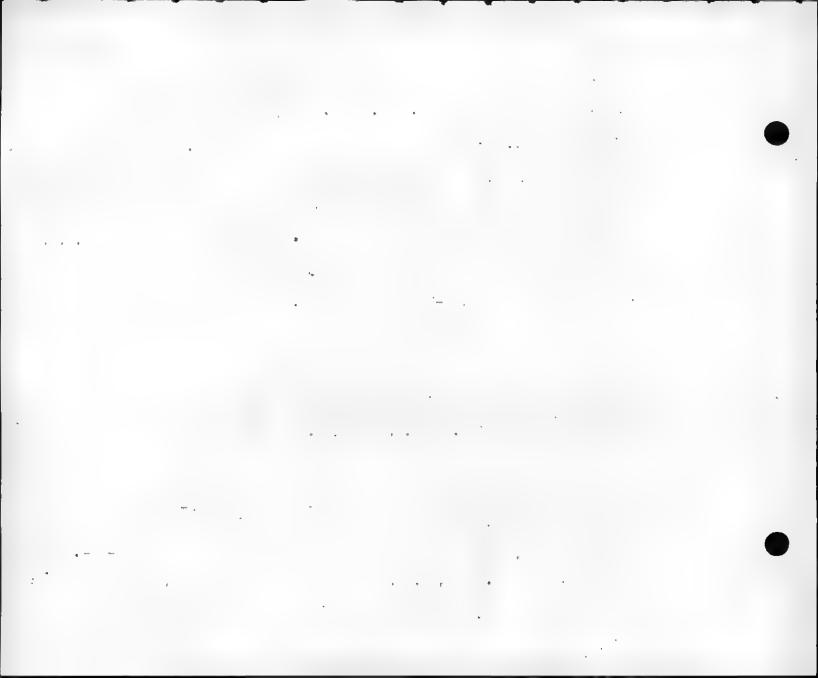


DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral and 2 r death. hours after death. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) Carrell a. COUNTY a. STATE b. COUNTY been signed by the attending physician and completely filled in my the ithe burial-transit permit. Then mease remove carbon papers. Pages 1 or to burial, cremation, or removal. And in any event, within 72 hours after Maryland Carrell MARYLAND c. CLTY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b 0.1771 Westminster Sykesville
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital Springfield State Hospital) e. IS RESIDENCE d. STREET ADDRESS give street address) ON A FARM? 180Washington Re NO be executed within NAME OF DATE Month Year First Middle Last 4. DECEASED C/6.501 DEATH Jan. 19 66 (Type or print) A AGE (In years | IFUNDER 1 YEAR | IFUNDER 24 HRS Male 6. COLOR OR RACE 7. MARRIEO NEVER MARRIED F Jast birthday) Months White Oays Hours WIOOWED X DIVORCED 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR during most of working life, even if retired) 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) COUNTRY? death certificate be U.S.A. Maryland ARM Farmer
13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Frank Raver 15. WAS DECEASED EVER IN U.S. ARMEO FORCES? INFORMAN Address 16. SOCIAL SECURITY NO. (Yes, no, or unkown) | (If yes give war or dates of service) Records Springfield Hosp. Sykesville. Md INTERVAL BETWEEN CAUSE OF BEATH [Enter only one cause per line for (a), (b), and (c).] The law requires that the DANGE AND DEATH BronchoPneumonia PART I. DEATH WAS CAUSED BY: D HOSPITAL OR ATTENDING PHYSICIAN: The law requires that ti Page 4 may be retained by the hospital or attending physician. IMMEDIATE CAUSE (a) Weeks Decubitus Ulcers Infected DUE TO Conditions, if any, which (b) gave rise to immediate DUE TO cause (a), stating has be as th prior 1 underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELATED TO THE TERM IN ALL DISEASE CONDITIONS CONTRIBUTION DEATH BUTNOT RELATED TO THE TERM IN ALL DISEASE CONDITIONS CONTRIBUTION DE LA SERIE DESTRUCTURA DEL SERIE DE LA SERIE DESTRUCTURA DEL SERIE DE LA SERIE DE L WAS AUTOPSY PERFORMED? CERTIFICATION 19. DIRECTOR: After this certificate has 3 should be detached for use led with the State Dept. of Health 1 NO 🛖 YES T 20a. ACCIDENT WAS UNDERLYING [ DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) OR CONTRIBUTING T CAUSE OF OFATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL (State) TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) (County) factory, street, office bldg., etc.) Hour a.m. While Not While at work at work that (I) (we) last 21. I certify that (I) (this hospital) attended the deceased from M. from the causes and on the date stated above. saw the deceased alive on. and that death occurred at 22b. DATE SIGNED 22a, SIGNATURE/ TO FUNERAL DIRECTOR DATE Should be filed v 1-1-66 **ATTENDING** STAFF PHYS. M.D. DIRECTOR PHYS. O HOSPITAL Sykesville, Maryland PHYSICIAN'S Wise LLL. M.D. NAME OF CEMETERY OR CREMATORY LOCATION (City, town or county) (State) BURIAL, CREMATION, 23b. DATE THEREOF 23c. REMOVAL (Specify) 2 12/14 **ADDRESS** REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE FUNERAL DIRECTO 1966

MARYLAND STATE DEPARTMENT OF HEALTH

VR A15 (4) 15M 4-64





RYLAND STATE DEPARTMENT OF HEALTH PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral 1. PLACE OF DEATH 2. USUAL RESIDENCE Where decressed lived, if institution, Residence before edmission e. COUNTS b. COUNTY e. STATE by the and 2 death. MARYLAND b. CITY OR TOWN of outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL end give namest town) write RURAL and give/nearest town) Woodbine MAME OF HOSPITAL OR INSTITUTION (if not in hospite, pive street eddress) e. 15 RESIDENCE d. STREET ADDRESS ON A FARM? 6429 Cedonia Avenue YES NO T papers. NAME OF 4. DATE Yea Month DECEASED Type or print DEATH B. DATE OF BIRTH AGE (In years 1 IF UNDER 1 YEAR IF UNDER 24 HRS. MARRIED last birthday) Months WIDOWED [ DIVORCED CUPATION (Give kind of work 12. CITIZEN OF WHAT COUNTRY? done during most of working I fa, even if refired)
Housewife Housewife alto. Md. Diease 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME George Easter Caroline Seckle 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16. SOCIAL SECURITY NO. 1 17. INFORMANT Address (Yes, no, or unkown) (If yes give wer or dates of service) Mr Henry Schmidt 1911 Leyden Road No 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (e) DUE TO Conditions, if eny, which geve rise to immediate cause DUE TO (e), steting the underlying cause lest. PART I. OTHER SIGN FICANT CONDITIONS CONTRIBLTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) WAS AUTOPSY PERFORMED? NO 20%. ACC DENT WAS UNDERLYING LI OR CONTRIBUTING LI CAUSE OF DEATH 20b. DESCRIBE HOW INJURY OCCURED. (Entar nature of injury in Port I or Pert II of Itam 18.) (IF EITHER, NOTIFY MEDICAL EXAMINER! 20c. TIME OF INJURY Month, Day, Yeer 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, ' 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Not While While Hour a.m. el work et work a.m. 21. | certify that (I) (this hospital) attended the deceased from... saw the deceased alive on. and that 22b. DATE 22a SIGNATURE SIGNED ATTENDING MED. STAFF DIRECTOR PHYS. PHYS. M.D PHYSIQIAN 9 22d. ADDRES NAME (Type) director, pe filed v 23a. BURIAL, CREMAT ON, 23d. LOCATION (City, town or county) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (State) REMOVAL (Spacify) Baltimore City Western Cemetery Burial ADDRESS 24 FUNERAL DIRECTOR'S SIGNATURE 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) 15M 7/61

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death. Page 4



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH death. funeral and death. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. COUNTY b. COUNTY by the fine Pages 1 urs after aftıır Carroll MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) oon papers. Pag within 72 hours hours Westminster Westminster 2 weeks <u>\_</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) filled d. STREET ADDRESS 14 Webster Street Carroll County General Hospital d completely fove carbon p within NAME OF Middle Last DATE Month DECEASED OF event. AGNES B. SCHWEIGART (Type or print) DEATH Jan. executed 5. SEX 6. COLOR OR RACE DATE OF BIRTH AGE (In years | IF UNDER 1 YEAR | IF UNDER 24 HRS. 7 MARRIED NEVER MARRIED Jast birthday) Months | Days 18. female white Feb. WIDOWED A DIVORCED [ 10a. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) be during most of working life, even if retired)
housewife INDUSTRY Carroll County, Maryland physical plea 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME remiliva William H. Bankert Annie R. Reigle Address 414 15. WAS DECEASED EVER IN U.S. ARMED FORCES? trannit permit. 16. SOCIAL SECURITY NO. | 17. INFORMANT (Yes, no, or unkown) (If yes give war or dates of service) Monais V Bankert Martinsburg. tile 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c), á PART I. DEATH WAS CAUSED BY: or attending physician, been signe≡ the buriar-tran or to burial, cre IMMEDIATE CAUSE (a) **DUE TO** Conditions, if any, which gave rise to immediate the l DUE TO cause (a), stating the underlying cause last. as CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) use for use Health certificate 20a. ACCIDENT WAS UNDERLYING TO DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) After this certified be detached for State Dept. of H DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, farm, 20f. (City or town) factory, street, office bldg., etc.) Hour a.m. - Not While at work at work P 21. I certify that (I) (this hospital) attended the deceased from director, page 3 should should be fired with the 7 P.M. from the causes and on the date stated above. saw the deceased alive on and that death occurred at. 22a, SIGNAJURE ATTENDING M.D. PHYS. DIRECTOR PHYS 22c. PHYSICHIN'S director, p 22d. ADDRESS NAME (Type) BURIAL, CREMATION, 23b. DATE THEREO 23a. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) REMOVAL (Specify) Westminster. Md. Jan. 1966 Westminster Cemetery ADDRESS 25b. REGISTRAR'S SIGNATURE REC'D BY REGISTRAR

MARYLAND STATE DEPARTMENT OF HEALTH

e. IS RESIDENCE ON A FARM?

Year

1966

Hours

Spring St.

INTERVAL BETWEEN

ONSET AND DEATH

WAS AUTOPSY

(State)

(State)

PERFORMED? NO P

YES [

(County)

YES

Day

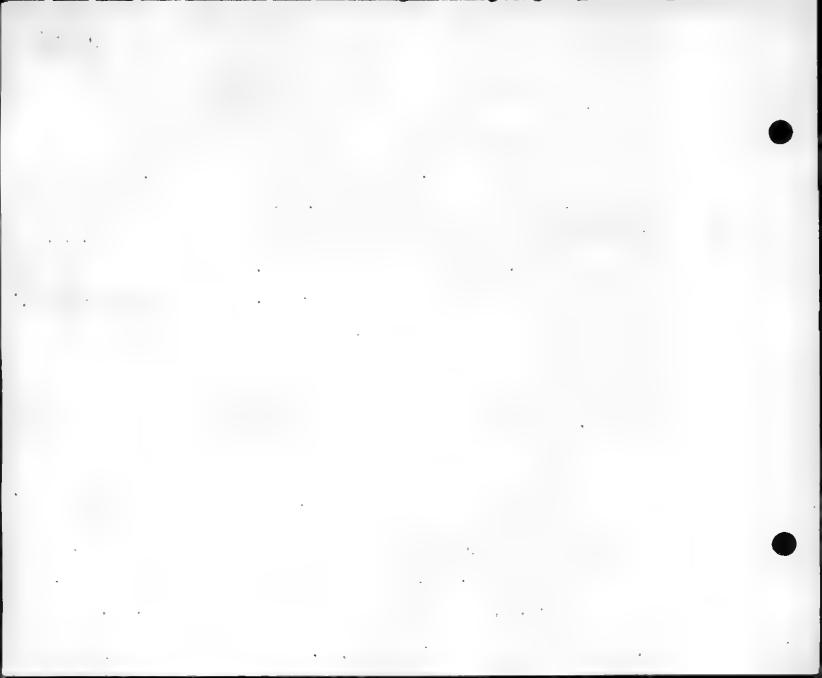
12. CITIZEN OF WHAT

U.S.A.

COUNTRY?

NO A

certificate eat The law requires that the PHYSICIAN: ATTENDING O HOSPITAL VR A15 (4) 20M 1/65



## FOR STATE HEALTH DEPT.

EXAMINED: This certificate should be executed within 24 hours after death. If any delay is certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral mould be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be pages n and 2 with the State Department in any event within 72 hours after death. esed as a burial-transit permit. File to burial, cremation, or removal, and please execute the certificate, writing the director. Page 4 should be forwarded to the retained for your files. 3 should be agent, prior t TO FUNERAL DIRECTOR: Page MARYLAND STATE DEPARTMENT OF HEALTH

	Division of	STATISTICAL RESE	ARCH AND RECORDS	, 301 W. PRESTON	N STREET, BALTIMORE	1, MARYLAND
ŀ	00573	MEDICAL	EXAMINER'S	CERTIFICATI	E OF DEATH	_0.0563
1.	PLACE OF DEATH				CE (Where deceased lived, If instit	ution: Residence before admission
	Car	roll	MARYLAND	a. STATE	d.	V- xichocicax
	b. CITY OR TOWN (If or	utside corporate limits, ve nearest town)	C. LENGTH OF STAY IN 1b		outside corporate limits, write	RURAL and give nearest town
	Westminste			/ Ba	altimore 📑	. 4
			ospital, give street address)	d. STREET ADDRESS		e. IS RESIDENCE DN A FARM?
S	trand Ave.	, Rt.5.		3121 Pel	lham Avenue	YES NO
3.	NAME OF DECEASED	First	Middle	CUEDBADD	4. DATE Month	Day Year
	(Type or print)	JOHN	ALFRED	SHEPPARD	DEATH Janual	
5.		LOR OR RACE 7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH	l leet hirthday) A	UNDER 1 YEAR IF UNDER 24 HR
	VIVE TO TO	hite   WIDOWED		10/8/1890	/5 yrs.	
10 du	a. USUAL OCCUPATION (GIVENING MOST OF WORKING HIS	ve kind of work done 10b. k , even if retired) i	(IND OF BUSINESS OR INDUSTRY		tate or foreign country)	12. CITIZEN OF WHAT COUNTRY?
	Maintenanc		Franke & Sc		to. Md.	
13	. FATHER'S NAME	loo Shoppar	d	14. MOTHER'S MAIL		
L		les Sheppar				
1 di	i. WAS DECEASED EVER IN es, no, or unkown) ](If yes;	U.S. ARMED FORCES?   16. give war or dates of service)		INFORMANT	Address	
	yes   WW	1 215-	09-2115 R	ith Smoot	Sheppard, wit	
		[Enter only one cause per	line for (a), (b), and (c).]	-0	0.6.	INTERVAL BETWEEN
	PART I. DEATH W.	EDIATE CAUSE (a)	rouler	1 Turen	yourses ale	W Dudte
	4 1	DUE TO	50 00 f			15420.
	Conditions, if any, w		yrege	ullean,	<del></del>	
	cause (e), stating	the DUE TO	1111111111	wild		74.60
1	undarlying causa last,	CANTCONDITIONS CONTRIB	UTINA TA BEATH BUY MATER	ATEN YOTHE TERMINAL	DICTACT FROM DIMINISTRALIVENTINES	ARTICAL DIS. WAS AUTOPSY
	FAUL OF A LURE WARRIET	ONNI CONDITIONS CONTRID	OTTOM TO DESTINOUT DOLLINOT MEET	MICE TO THE LEMINITUM		YES NO TO
	Pho syrehyar dario	F WAR   20b.	PROPERTY NOW WILLIAM OF STATE	IRRED. Tentar nutura o	f injury in Part I or Part II of	
15	20e. EXTERNAL CAUS PRIMARY OF CONTR CAUSE OF DEATH,	ÎBUTÎNG 🖂			, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
MEDICAL CENTIFICATION	206. TIME OF INJURY		INJURY OCCURRED   20e. PL	ACE OF INJURY (Homa, I	arm, 20f. (City or town)	(County) (State)
멸	Hour a.m.		Not White fact	ory, atreet, office bidg., e	itc.)	
1 2	p.m.			ld on Autonou 🗔	Inspection X. Inquir	y . and in my opinio
	*	_	mains described ebove, he	icide . Homici		
	death teanited tro	m: Netural ceuses	AGEIGENT, SO	CHIEF MEDICA		
П	ACTUAL /	166	Torgin la		DICAL EXAMINER	22. DATE SIGNED
	SIGNATURE (A		They was	Light.	CAL EXAMINER A	1-71-66
\	EXAMINER'S NAME (Typa)	//		FARRIETE STEEL	Kleing Books, by Walley St	recordly will
23		. 23b. DATE THEREOF	23c. NAME OF CEMETER	Y OR CREMATORY	23d. LOCATION (City, toy	**
	BURIAL CREMATION. REMOVAL (Specify) BURIAL	2/4/66	Balto.Nat.	Cem.	Baltimore,	Md.

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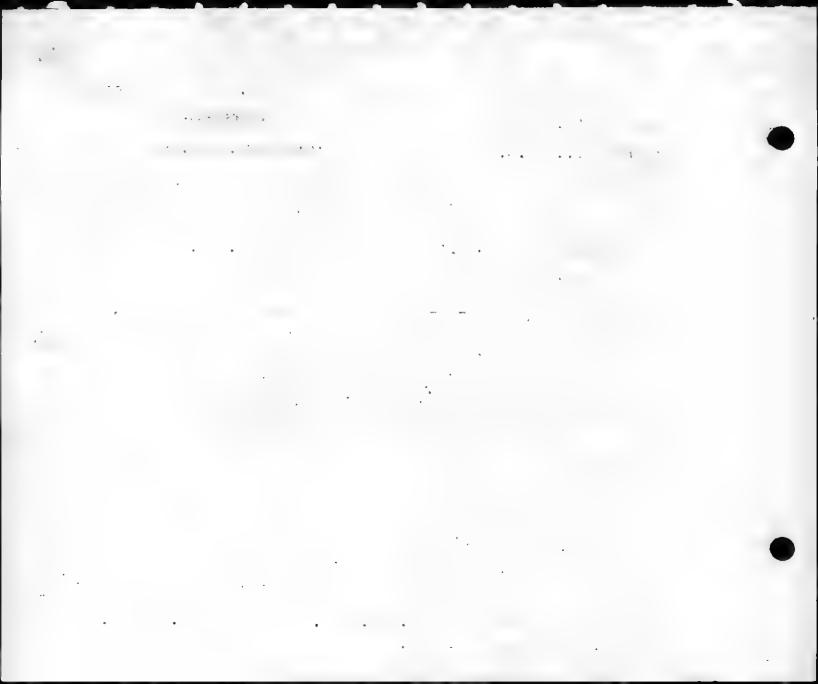
Baltimore, Md.

THC.

24. FUNERAL DIRECTOR
Schimunek Funeral Home,
3331 Brehms Lane

DATE

250. REC'D BY REGISTRAR 256. REGISTRAR'S SIGNATURE



	DIVISIO	IN OF STATIST					PARTMENT OF		LTH EET, BALTIMORI	E 1, MA	RYLAND
	00574				CERTIFI						110564
1.	a. COUNTY Carrol	1	- ata Umita		MARYE		a. STATE		deceased lived, if institute b. COUNTY Ba. Corporate limits, write	,	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)  Sykesville  3mos.12dys.						corporate limits, write	RUKAL ar	IQ RIAG LEGICAL LOWIN			
	d. NAME OF HO	LLE OSPITAL OR INSTITUT	FION (If not	in hospita	il, give street a	ddress)	d. STREET ADDRESS		AN AL PER	7	e. IS RESIDENCE
	Springf	ield State	Hosp	ital			2216 Gara	rison	Blvd.		ON A FARM?
	NAME OF DECEASED (Type or print)	NE	First		Middle ROGER		Last SHOWACRE	4. DA	TE Month		Day Year 28 19 66
	SEX	6. COLOR OR RACE	/ 1 11/25/11		NEVER MARRIED	- IA	8. DATE OF BIRTH		last birthday) M	HARRER 1 V	YEAR IF UNDER 24 HRS.
	Male	White TION (Give kind of wor	WIDOV		DIVORCED		3-18-06	County & Q	59 yrs. "" tate, or foreign country)		IZEN OF WHAT
dur	ring most of work	king life, even if retil	ired)	INDUSTI	RY			arylai		COU	NTRY?
	FATHER'S NAM		CPa41-	HELLI.			14. MOTHER'S MAII			Uab	•#•
	Nelson Sh						Elma D.	Schn	eidereith		
15. (Ye	. WAS DECEASED (	EVER IN U.S. ARMEDI (If yes give war or date	FORCES?	16. SOCIA	AL SECURITY NO.	. 17.	INFORMANT		Address		
_				Non			cords, Spri	ingfi	eld State H		
		any, which	BY: Se SE (a) Se UE TO (b) Mu	ptice	emia, or	gani	sm undeterm		oitus ulcers		Neeks
	cause (a), st underlying caus	trating the [	(c)								
CERTIFICATION			TIONS CONT	RIBUTINGT	TO DEATH BUTN	OTRELA	TED TO THE TERMINAL	DISEASEC	ONDITION GIVEN IN PA	RT1(a)	19. WAS AUTOPSY PERFORMED? YES X NO
	20a. ACCIDENT OR CONTRIBUTI (IF EITHER, NO	WAS UNDERLYING ING I CAUSE OF DE ITIFY MEDICAL EXAM	EATH MINER)	). DESCRI	IBE HOW INJUR	RY OCCU	RRED. (Enter nature o	if Injury In	n Part I or Part II of I	tem 18.)	
MEDICAL	20c. TIME OF I Hour a.m p.n		WI	hlle No	OCCURRED 2 Not While at work	factor	CE OF INJURY (Home, fa 1y, street, office bldg., e	arm, 20f etc.)	f. (City or town)	(Count	ty) (State)
		fy that (I) (this hose ceased alive on	ospital) atte 1–28-		e deceased fr		death occurred at	9 3:35 <sub>M</sub> ,	to 1-28-66 from the causes an	d on the	
	ZZZ. SIGNATUR	CIM	17.	7 //	us.	M.D.	ATTENDING T	MED, DIRECTOR	STAFF	1-28	E SIGNED
	22c. PHYSICIA NAME (Ty	AN'S ype) Octavio	A. Ru		17	IVI.U.	22d. ADDRESS	Sprin	ngfield Statesville. Mary	te Ho	spital
23a.	BURIAL, CREM. REMOVAL (Spe	eclfy) /3//	E THEREOF	23c.	Druin	METERY	OR CREMATORY	23d.	LOCATION (City, town	or count	ransland
24.	Im 1 T	Tichne	. 28	A 10	ADDRESS	(0)	On Compate F		1966 F		SIGNATURE

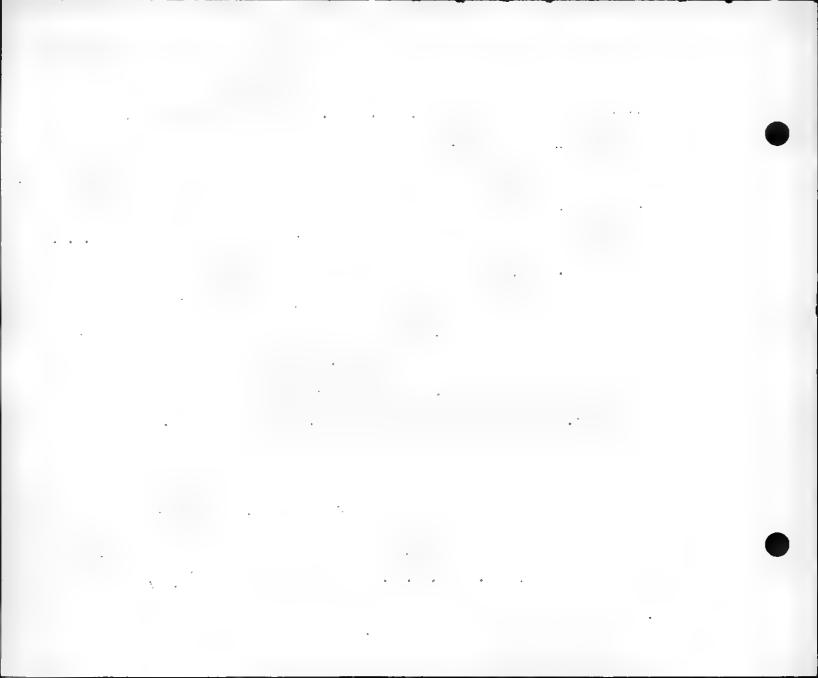
VR A15 (4) 15M 4-64



15M 4-64



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 576 CERTIFICATE OF DEATH and 2 death funeral and 2 1. PLACE OF DEATH 8. COUNTY USUAL RESIDENCE (Where deceased lived, If (institution: Residence before admission) b. COUNTY etely filled in by the furbon papers. Pages 1 a within 72 hours after d Carroll Maryland MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) hours 9vrs.9mos.11dvs Svkesville Rural - Westminster d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) e. IS RESIDENCE d. STREET ADDRESS ON A FARM? YES ND 🔽 Springfield State Hospital within letely carbon NAME OF Éirst DATE Year Middle Last 4. Month DECEASED OF (Type or print) car car WILL TAM SPENCER 19 .TOHN JANUARY executed 6. COLOR OR RACE DATE OF BIRTH ACE (in years | IF UNDER 1 YEAR last birthday) | Months | Days 7. MARRIED T NEVER MARRIED Hours 80 Male 5-27-1885 White WIDOWED | DIVORCED [ nding physician Then please ver removal, and in lease re 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 12. CITIZEN OF WHAT 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) COUNTRY? U.S.A. Pipe fitter Termo. Marvland death certificate 13. FATHER'S NAME MOTHER'S MAIDEN NAME attending permit. Then James P. Spencer Mary Evans 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. Address permit. 5 (Yes, no, or unknown) I (If yes nive war or dates of service) No Records, Springfield State Hospital None cremation, the 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) INTERVAL BETWEEN The law regulres that the ONSET AND DEATH á PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a) al-transi Bronchopneumonia Davs retained by the hospital or attending physician. has been signed to as the burial-tran prior to burial, cra DUE TO Arteriosclerotic heart disease Years Cenditions, If any, which gave rise to immediate DUE TO cause (a), stating the Generalized arteriosclerosis Years underlying cause last. has as CERTIFICATION PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION CIVEN IN PART 1(a) 19. WAS AUTOPSY for use Health use PERFORMED? CBS assoc. with cerebral arteriosclerosis, without qualifying phase certificate NO X YES PHYSICIAN: 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of Item 18.) After this certifid be detached for State Dept. of H MIDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 120e, PLACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) factory, street, office bldg., etc.) Hour a.m. Not White at work at work -DIRECTOR: Jage 3 should lied with the the 21. I certify that (I) (this hospital) attended the deceased from . Arom the causes and on the date stated above. L-17-66 saw the deceased alive on and that death occurred at 22b. DATE SIGNED 22a. SIGNATURE be page ATTENDING STAFF PHYS. 1-17-66 TX. M.D. DIRECTOR TO MOSPITAL TO FUNERAL 22d. ADDRESS Springfield State Hospital 22c. PHYSICIAN'S director, p should be NAME (Type) Ruiz. Octavio 23d. LOCATION (City, town or county) NAME OF CEMETERY OR CREMATORY (State) BURIAL, CREMATION, 23b. DATE THEREOF 23c. REMOVAL (Specify) recrea 24. FUNERAL DIRECTOR 25a. REC'D BY RECISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) 20M



10 DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is recessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

VR AISME (5) 5M 1/65

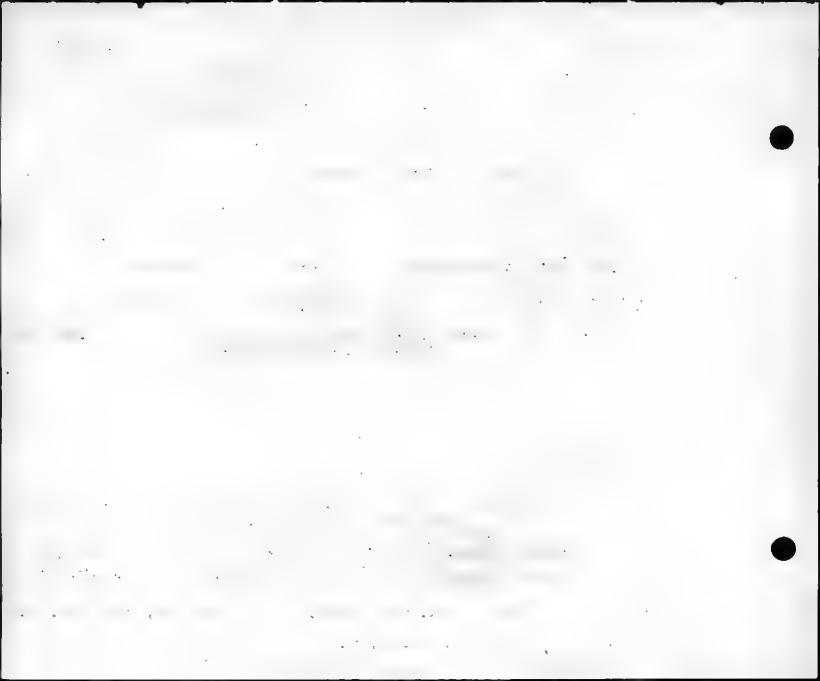
TO FUNERAL DIRECTOR. Page 3 should be used as a burial-transit permit. File pages 1, age 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

A.	00577 MEDICAL EXAMINER'S	CERTIFICATE OF DEATH
Ā	1. PLACE OF DEATH a. COUNTY	2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
	CARROLL COUNTY MARYLAND	MARYLAND CARROLL
ı	b. CITY OR TOWN (If outside corporate limits.   c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
1	RURAL WESTMINSTER 9485.	PURAL WESTMINSTER, MD
ľ	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)	d. STREET ADDRESS     e. IS RESIDENCE ON A FARM?
k	OLD TANEY TOWN ROUD	RD TO CLD TANEYTOWN MEAD YES ( NO )
ľ	3. NAME OF First Middle DECEASED	Last 4. DATE Month Day Year
ŀ	(Type or print) PAUL ISRUCE S	TARNER DEATH JAN. 18 1966
ı	5. SEX   6. COLOR OR RACE   7. MARRIED   NEVER MARRIED	8. DATE OF BIRTH  9. AGE (In years   IF UNDER 1 YEAR   IF UNDER 24 HRS.   last birthday)   Months   Days   Hours   Min.
ŀ	10a. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR	11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT
1	during most of working life, even if retired) INDUSTRY	COUNTRY?
ŀ	13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
١	JACOB D. STARNER	JESSIE BELLE DAYHOFF
ľ	(Yes, no, ar unknown) (If yes give war or dates of service)	INFORMANT Address
	NO 100- 220-34-5740 50.	M. DAVID STARNER WESTMINSTER, MA
	18. CAUSE DF DEATH [Enter only one cause per life for (a), (b), and (c).]	ONSET AND DEATH
1	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (8)	
1	LGOX DUE TO C	I d' On Dill a R Styliac
1	Conditions, if any, which gave rise to immediate (b)	the chief the conting the
	cause (a), stating the underlying cause last.	Mellitus (milit) Shighel
1	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELA	ATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(8) 13. WAS AUTOPSY PERFORMED?,
	I CAT	YES NO
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE PRIMARY OF CONTRIBUTIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE PRIMARY OF CONTRIBUTIONS CONTRI	URRED. (Enter nature of injury in Part I or Part II of Item 18.)
-	facto	ACE OF INJURY (Home, farm, 20f. (City or town) (County) (\$tate) bry, street, office bidg., etc.)
	Hour a.m.  p.m.  19 at work at work	
	21. I certify that I took charge of the remains described above, he	ld an Autopsy 🔲 , Inspection 💢 , Inquiry 🔲 , and in my opinion
Ì	death resulted from: Natural causes , Accident , Su	icide [], Homicide [], Undetermined manner []
1	ACTUAL 114/0 ( ) TO	CHIEF MEDICAL EXAMINER  22. DATE SIGNED
	SIGNATURE	M.D. ASSISTANT MEDICAL EXAMINER \
	EXAMINER'S NAME (Type) IN GHENN SPEICHER	Address Street Shytodra or Educated Street les his reall
Ì	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETER	Y OR CREMATORY 23d. LOCATION (City, town or county) (State)
	24, FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR   25b. REGISTRAR'S SIGNATURE
1	Same to Soull hest Mines	P UD IAN 20 1000 PChamlas Judge
~	Money or of States V. 11-21/11/12/El	( )12) DATES IN 20 1000   7



MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

	E UF DEATH 0.0560
1. PLACE OF DEATH a. CDUNTY	2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
Carroll	a. STATE Maryland b. COUNTY Washington
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
write RURAL and give nearest town)	77
Sykesville 13 Yrs. 8Mo. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	Hagerstown e. Is residence
a. TARRE OF ROSPITAL DR TASTITUTION (II TIOL III MOSPILAL, BIVE STIESE AUDIESS)	ON A PARMIT
Springfield State Hospital	245 East Howard St. YES NO
3. NAME OF First Middle DECEASED	Last 4. DATE Month Oay Year
	wartz DEATH Jan. 30 1966
5. SEX   6. COLOR OR RACE   7. MARRIED   NEVER MARRIED	8. DATE OF BIRTH 9. AGE (In years   IF UNDER 1 YEAR   IF UNDER 24 HRS.
Female White WIDOWED DIVORCED	3-11-1910 SS yrs. Hours Min.
10a. USUAL OCCUPATION (GIVE kind of work done   10b. KIND OF BUSINESS OR	11 BIRTHPLACE (County & State, or foreign country)   12. CITIZEN OF WHAT
	COUNTRY?
None 13. FATHER'S NAME	Virginia U.S.A.
	14. MOTHER S RIFIDER TRAILE
James Swartz	Mabel ?.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. (Yes, no, or unknwn) (If yes give war or dates of service)	INFORMANT Address
No None	Hospital Records
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN
PART I. DEATH WAS CAUSED BY: Brenchopneumonia	DASET AND DEATH
24.	
	due to large gangrenous, Weeks
gave rise to immediate infected, decubita	s wicers
cause (a), stating the DUE TO	
	ATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 119. WAS AUTOPSY
The state of the s	PERFORMED?
D D D D D D D D D D D D D D D D D D D	YES NO
20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCC	
OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	VES NO ::URRED. (Enter nature of injury in Part I or Part II of Item 18.)
20a. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCC OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20b. PL	YES NO  URRED. (Enter nature of Injury In Part I or Part II of Item 18.)  ACE OF INJURY (Home, farm.! 20f. (City or town) (County) (State)
20a. ACCIDENT WAS UNDERLYING ☐ 20b. DESCRIBE HOW INJURY OCC OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PL Hour a.m. While at work ☐ fact at work ☐ 19	CURRED. (Enter nature of Injury In Part I or Part II of Item 18.)  ACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) tory, street, office bldg., etc.)
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20s. PL Hour a.m. While Not While fact p.m. 19 at work at work	CURRED. (Enter nature of Injury In Part I or Part II of Item 18.)  ACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) tory, street, office bldg., etc.)
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20s. PL Hour a.m. p.m. 19 at work at work 21. I certify that (I) (this hospital) attended the deceased from	CURRED. (Enter nature of Injury In Part I or Part II of Item 18.)  ACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) tory, street, office bldg., etc.)
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20s. PL Hour a.m. p.m. 19 at work at work 21. I certify that (I) (this hospital) attended the deceased from	CURRED. (Enter nature of Injury In Part I or Part II of Item 18.)  ACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) tory, street, office bldg., etc.)
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED fact work not while at work at work at work 21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 1-30 1966, and the 22a. SIGNATURE	ACE OF INJURY (Home, farm, 20f. (City or town) (County)  State)  The state of the s
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20s. PL Hour a.m. 19 while at work 1 fact work 21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 1-30 1966, and the 22a. SIGNATURE  R. C. Jajonalie M. D. M.	ACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) tory, street, office bldg., etc.)  5-15  1252  to 1-30  ATTENDING MED.  STAFF  226. (City or town) (County)  (State)  270. (City or town)  (State)  280. Date stated above.
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PL Hour a.m. 19 While Not While at work 21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 1-30 1966, and the 22a. SIGNATURE  R. C. Jajonalie M. D. M. D. M. D. M. D. NAME (Type)	ACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) cory, street, office bidg., etc.)  5-15 152 to 1-30 1966, that (I) (we) last at death occurred at PM, from the causes and on the date stated above.  D. ATTENDING MED. STAFF 1-30-66  22d. ADDRESS
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PL Hour a.m. p.m. 19   While Not While at work   fact at work   21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 1-30 1966, and the 22a. SIGNATURE    R. C.   Cajouche M. D.   22c. PHYSICIAN'S NAME (Type)   Dr Lajonchere M. D.	ACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) tory, street, office bidg., etc.)  5-15 1252 to 1-30 1966, that (I) (we) last at death occurred at 20 M, from the causes and on the date stated above.  D. ATTENDING MED. STAFF 22b. DATE SIGNED 22d. ADDRESS  Sykesville Md.
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20s. PL Hour a.m. 19 while at work at work 21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 1-30 1966, and the 22a. SIGNATURE 22c. PHYSICIAN'S NAME (Type) Dr Lajonchere M.D.  23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETER REMOVAL (Specify)	ACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) to 1–30 , 19.66 , that (I) (we) last at death occurred at 3PM, from the causes and on the date stated above.  D. ATTENDING MED. STAFF 22b. DATE SIGNED 22b. DATE SIGNED 22c. ADDRESS SYKESVILLE, Md.  RY OR CREMATORY 23d. LOCATION (City, town or county) (State)
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20b. PL fact Hour a.m. 19 while at work 1 at work 21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 1-30 1966, and the 22a. SIGNATURE R. C. fajourable M. D.  22c. PHYSICIAN'S NAME (Type)  Dr Lajonchere M. D.  23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETER Removal (Specify)  Burial 2/3/66 Rose Hill (	ACE OF INJURY (Home, farm, 20f. (City or town) (County) (State)  S-15 1252 to 1-30 19.66, that (I) (we) last at death occurred at 32 M, from the causes and on the date stated above.  ATTENDING MED. STAFF 1-30-66  22d. ADDRESS Sykesville Md.  ATTENDING 22d. ADDRESS Sykesville Md.  ATTENDING MED. 22d. ADDRESS (Sykesville Md.)  ATTENDING MED. 23d. LOCATION (City, town or county) (State)
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20s. PL Hour a.m. 19 while at work at work 21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 1-30 1966, and the 22a. SIGNATURE 22c. PHYSICIAN'S NAME (Type) Dr Lajonchere M.D.  23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETER REMOVAL (Specify)	ACE OF INJURY (Home, farm, 20f. (City or town) (County) (State) tory, street, office bldg., etc.)  5-15  152  to 1-30  1966, that (I) (we) last at death occurred at PM, from the causes and on the date stated above.  D. ATTENDING MED. STAFF 22b. DATE SIGNED 1-30-66  22d. ADDRESS  Sykesville Md.  RY OR CREMATORY 23d. LOCATION (City, town or county) (State)  Cemetery 45a REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

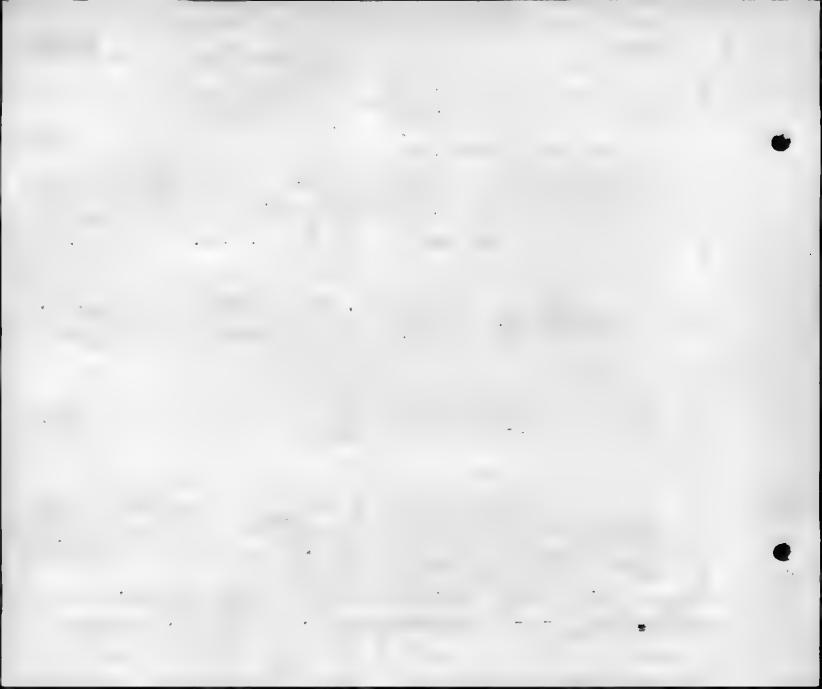
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending proposition and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. 24 hours after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Page 4 may be retained by the hospital or attending physician. VR A15 (4)

15M 4-64



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH funeral I. PLACE OF DEATH 2. USUAL RESIDENCE (Whara deceased lived, If institution: Residence before admission) e. COUNTY b. COUNTY a. STATE CARROLL MARYLAND MARYI.AND CARROLL
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 돌었숙 b. CITY OR TOWN (if outside corporate limits, C. LENGTH OF STAY IN 16 write RURAL and give nearest town) APPROXIMAT MUDDIÆBURG .5 NEW WINDSOR <u>| |</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) e. IS RESIDENCE d. STREET ADDRESS ON A FARM? 01 YES NO ROTTE BROOKEF TELD completely 4. DATE NAME OF Month DECEASED OF DEATH (Type or print) TESTERMAN 19 66 NANCY JANE AGE (In years IF UNDER I YEAR) IF UNDER 24 HRS. 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH last birthday) Months and 186 FEMALE WIDOWED 17 DIVORCED physician 12. CITIZEN OF WHAT COUNTRY? 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (County & State, or foreign country) done during most of working life, even if retired) ASH COUNTY, N. C. U. S. A. HOUSEWIFE HOME 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME please attending KATHERINE MOCK JUNIOR MOCK 15. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16 SOCIAL SECURITY NO | 17. INFORMANT Address (Yes, no, or unkown) | (Ifyes give war or detes of service) MRS. CORDIE TESTERMAN. INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c),] ONSET AND DEATH PART I. DEATH WAS CAUSED BY, noars IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediata causa DUE TO (e), stating the undarlying cause fast. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART II.) 19. WAS AUTOPSY 90 PERFORMED? U NO X MUMONIO 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Itam 18.) 200 ACCIDENT WAS UNDERLYING [] OR CONTRIBUTING CAUSE OF DEATH 20s. PLACE OF INJURY (Home, farm, † 20f. (City or town) (County) (Slate) 20c. TIME OF INJURY 2Dd. INJURY OCCURRED | Month, Day, Year factory, streat, offica bldg., atc.) While Not While Hour a.m. el work at work p.m. / 19 19 last (1) ( last 21. 1 certify that (I) (this hospital) attended the deceased from .....19......., and that death occurred M. from the causes and on the date stated above 8/64 saw the deceased alive on DATE /SIGNATURE 22a ATTENDING DIRECTOR PHYS. FUNERAL 22c PHYSICIAN'S NAME (Typa) ADDRESS H. CARICOFE UNION BRIDGE. MARYLAND 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) 23a. BURIAL, CREMATION, 23b DATE THEREOF REMOVAL (Spacify) 0 REMOVAL #BURTAL 24 FUNERAL DERECTOR'S SIGNATURE 2Sa, REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Plianten

VR A15 (4) 1SM 7-62



1				MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARY	/LAND
FOR S				00581 MEDICAL EXAMINER'S CERTIFICATE OF DEATH	11.571
HEALTH	DEPT	C. 100	1.	PLACE OF DEATH  2. USUAL RESIDENCE (Where deceased lived, If institution: Reside a. COUNTY	ence before admission)
0)	و سه			Carroll Maryland Baltimor	e City
ssary nera ny be	Department after death.			b. CITY OR TOWN (if outside corporate limits, write RURAL and write RURAL and give nearest town)  c. LENGTH OF STAY IN 1b  c. CITY OR TOWN (if outside corporate limits, write RURAL and	give nearest town)
e fune	er d			Sykesville 2yrs.8mos.29dys. Baltimore 3 - 4	e. IS RESIDENCE
5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	e De	.		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  d. STREET ADDRESS  Common Standard Standar	ON A FARM?
elay it d 3 to Page	State	-	3	Springfield State Hospital 1403 W. Mosher St.	VES NO 3
any del 2, and PM3.	the 72 h		Ų,	OECEASED (Type or print) LORREY (LLOYD) JAMES THOMPSON DEATH JANUARY 27	19 66
		ľ	5.	SEX   6. COLOR OR RACE   7. MARRIED   NEVER MARRIED   8. DATE OF BIRTH   9. AGE (in years   FUNDER 1YE	EAR IF UNGER 24 HRS.
ath. If ages 1, form	2 with within			Male Negro WIDOWED DIVORCEO 4-4-03 62 yrs.	
프 스	l and event	Ì	10a dur	ring most of working life, even if retired)   INGUSTRY   COUNT	EN OF WHAT
# G PM	s 1 ny e			Bartender Maryland U	J.S.A.
urs af 18. aloni	pages 1 in any		13.	FATHER'S NAME  William Thompson  14. MÖTHER'S MAIOEN NAME  Namie Talbott	
24 hou n Item Office	File		15.	WAS DECEASED EVER IN U.S. ARMED FOR CEST   16. SOCIAL SECURITY NO.   17. INFORMANT Address	
S E			(Ye	es, no, or unknown) (If yes give war or dates of service) Unk. Records, Springfield State Hospit	al
uted within the pencil Examiner	permit. removal,			201 201 201 201 201 201 201 201 201 201	NTERVAL BETWEEN
Example Control	or or				ins / hrs.
CJ OR	burial-transit			DUE TO	ears
be exe pendin Medical	urial			gave rise to immediate (II)	Cals
should word " Chief !				couse (a), stating the DUE TO underlying cause last. (c)	
word Word	used as to burial,		NO	PART IL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e)	19. WAS AUTOPSY
the the	use to b	19	CATI	CBS assoc. with CNS syphilis, meningovascular, without qualifying phras	YES NO
certifica riting th ded to tl	ld be	×	CERTIFICATION	20a. EXTERNAL CAUSE WAS PRIMARY OF OF ONTRIBUTING CAUSE OF DEATH.  CAUSE OF DEATH.	
R: This cer ate, writin forwarded	3 shoulagent,			20c. TIME OF INJURY Month, Day, Year   20d. INJURY OCCURRED   20e. PLACE OF INJURY (Home, farm,   20f. (City or town) (County)	) (State)
icate e fo	ed ag		MEDICAL	Hour e.m.  p.m.  While Not While at work factory, street, office bidg., etc.)	25
ertiid b	Pag nate			21. I certify that I took charge of the remains described above, held an Autopsy X, Inspection, Inquiry,	and in my opinion
F EXA	OR: esign			death resulted from: Natural causes Accident , Suicide , Homicide , Undetermined manner	]
te #	REC:			ACTUAL CHIEF MEDICAL EXAMINER CHIEF MEDICAL C	22. DATE SIGNED
MED recut	9.5			SIGNATURE M.O. ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER	1-27-66
DEPUTY ease ex rector.	ERA alth	2		NAME (Type) W. Glenn Speicher, M. D. daids Silla Chicago de Court qui calle	Carrolly
DEPUT please e director.	o FUN of He		23a	a. BURIAL CREMATION, 23b. DATE-HEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county REMOVAL (Specify)	(State)
_		20	24.	FUNERAL DIRECTOR AGORESS 250. REC'D BY REGISTRAR 250. REGISTRAR'S S	43
VR A). 5M	5ME (5) 1/65	W()	_ \	W. MORN 9288 Montre DATE : B 4 1966 Pelloreles	Judge



	MARYLAND STATE DEPARTMENT OF HEALTH	
DIVISION OF STATISTICAL	RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMO	DRE 1, MARYLANI
COTOS	CERTIFICATE OF DEATH	11157

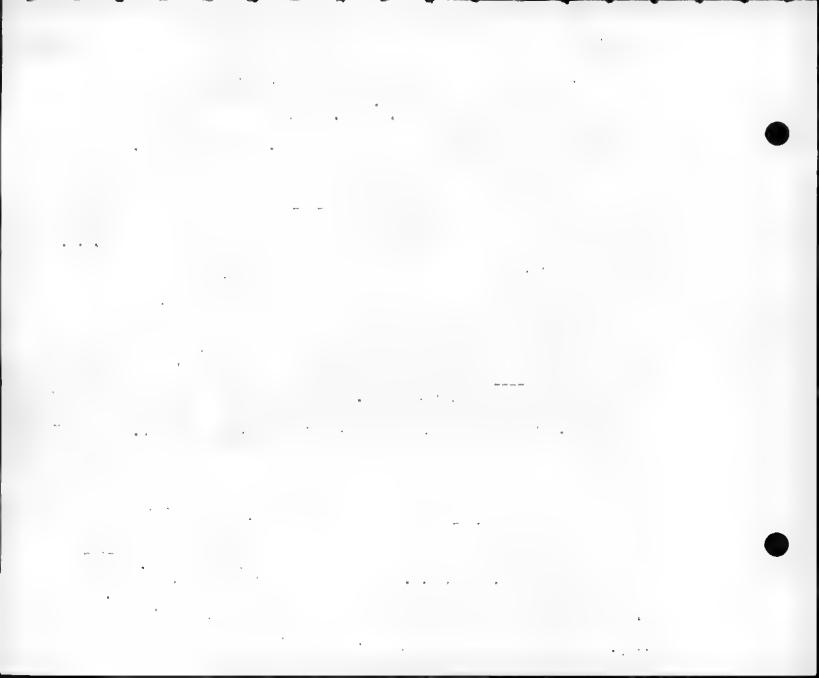
7	1_			OEK III IOA	L OI DEAL	**	00012			
	/1.	PLACE OF DEATH			1 2. USUAL RESIDEN	NCE (Where deceased lived, If Institution: I	Residence before admission)			
1	,	a. COUNTY			a. STATE	b. COUNTY	V			
		Carroll		MARYLAND	Maryl					
-		b. CITY OR TOW	N (if outside corporate limits and give nearest town)	, c. LENGTH OF STAY IN 15	c. CITY OR TOWN (	if outside corporate limits, write RURAL	i, and give nearest town)			
		Sykesvi	TTC	32 yrs. 9 ay	IT -	stown 2/-	4-			
		d. NAME OF HOS	SPITAL OR INSTITUTION (If no	t in hospital, give street address			e. IS RESIDENCE ON A FARM?			
			ield State Hos	pital	813 I	Lanvale Street	YES NO K			
	3.	NAME OF DECEASED	First	Middle	Last	4. DATE Month	Day Year			
		(Type or print)	JOEL	К.	TICE		18 19 66			
	5.	SEX	6. COLOR OR RACE 7. MAR	RIED 🦳 NEVER MARRIED 🗶	8. DATE OF BIRTH	9. AGE (in years IF UNDER last birthday) Months	R 1 YEAR   FUNDER 24 HRS.			
		Male	White wind	WED DIVORCED	8-24-89	, T Jis.				
	10a dur	. USUAL OCCUPAT	ION (Give kind of workdone) 1 ing life, even if retired)	Ob. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (	County & State, or foreign country) 12. C	ITIZEN OF WHAT OUNTRY?			
	-	arm hand		111001111	Marylan	ıd Ü	S.A.			
		FATHER'S NAM			14. MOTHER'S MA	IDEN NAME				
		David M	. Tice		Margar	ret O'Keefe				
	15.	WAS DECEASED	EVER IN U.S. ARMED FORCES?	16. SOCIAL SECURITY NO.   17	. INFORMANT	Address	-			
	(18	NO NO	(If yes give war or dates of service)	Unknown	Records, Spr	ringfield State Hosp	oital			
		18. CAUSE OF	DEATH [Enter only one cause	per line for (a), (b), and (c).]			INTERVAL BETWEEN			
1		PART 1. DE	ATH WAS CAUSED BY: IT	remia			DISET AND DEATH			
ı	PART I. DEATH WAS CAUSED BY: Uremia									
	DUE TO									
		Conditions, if any, which gave rise to immediate (b) Chronic pyelonephritis								
		cause (a), stating the DUE TO underlying cause last.								
	S									
	ATI	PARTIL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)  Schizophrenic reaction, other and unspecified								
	CERTIFICATION	200 ACCIDENT	WAS UNDERLYING ET	AP DESCRIPE HOW INCHES OF	OUDBED (Enter meture)	of Jahren Ja Bort I or Bort II of Itam 20	YES NO			
	ERI	20a. ACCIDENT WAS UNDERLYING   20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part   or Part   of Item 18.) OR CONTRIBUTING   CAUSE OF DEATH   (IF EITHER, NOTIFY MEDICAL EXAMINER)								
	ICA	20c. TIME OF I		fac	LACE OF INJURY (Home, tory, street, office bldg.,	farm, 20f. (City or town) (Co	ounty) (State)			
	MEDICAL	7.5 p.1		While Not While at work	,, - 1 ,					
		21. I certif	y that (I) (this hospital) at	tended the deceased from	1-9-34	19to 1-18-66 19	, that (I) (we) last			
			ceased alive on 1-		at death occurred at					
ļ		22a. SIGNATUI	RE PALACA	01/7.1			DATE SIGNED			
			Clarve (	( VEWB M	I.D. PHYS.	MED. STAFF 1-1	8-66			
		22c. PHYSICIA NAME (Ty			22d. ADDRESS	Springfield State H	lospital,			
	!		Octavio			Sykesville, Marylar				
	23a.	BURIAL, CREM REMOVAL (Spe	ATION, 23b. DATE THEREOF	23c. NAME OF CEMETE	RY OR CREMATORY	23d. LOCATION (City, town or co	ounty) (State)			
		18 28 E	ALLOAN: FO	HIVERVIEW	1	THISTEMALLIN	1101			
1	24.	EUNERAL DIRE	CTOR ,	ADDRESS	25a. R		R'S SIGNATURE			
1		alma(	Briller	milleams	JAN 169/ DATEN	20 1538 11 100010	Judge			
	I ver									

VR A15 (4) 15M 4-64

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then physical amove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and thrany event, within 72 hours after death.



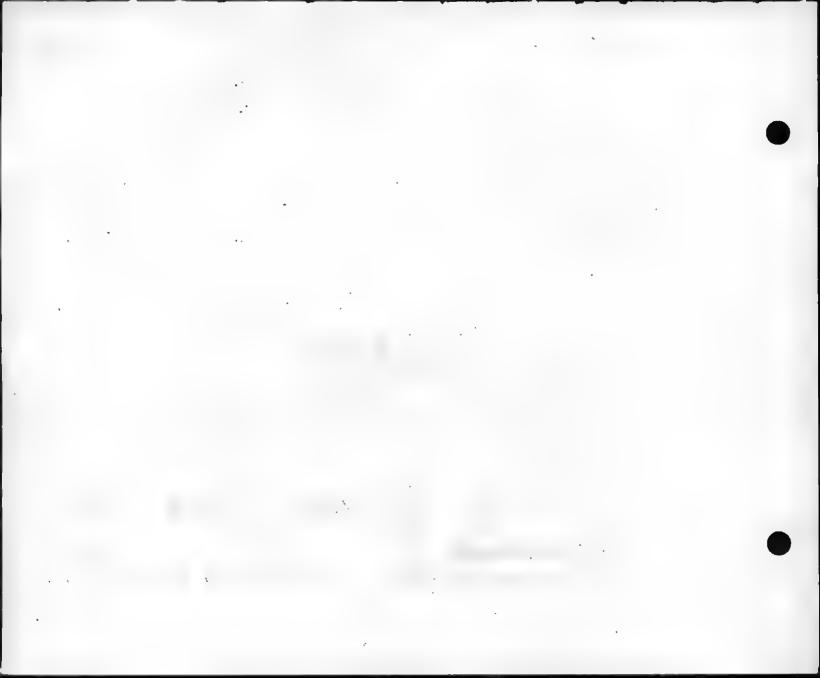


20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH



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<u> </u>	5		CERTIF	ICATE	-			0.0	575
a. CDUNTY	-	wwo]]			a. STATE			TY	
b. CITY DR TDW	N (if outside corp	orate limits.					ate Elmits, writ	te RURAL and gh	ne nearest town
			6 Mont	hs		Westmin	ster		,
d. NAME OF HO	SPETAL OR INSTITU	JTION (if not In	hospital, give street	address)	d. STREET ADDRESS			6	. IS RESIDENC ON A FARM?
	ordan Nur								ES NO X
DECEASED						4. OATE	_	- 1	Year
. SEX	6. COLOR OR RA			ED [ ] 8		10.8	CE (In wager II	E HAIDED 1 VEAD	19 66 IF UNDER 24 HR
Female		7. 10741111			/11/1877	la la		Months Days	Hours Min.
Da. USUAL OCCUPAT	IDN (Give kind of w	orkdone   10b.	KIND OF BUSINESS D		//	County & State, or	7101 1	12. CITIZEN	F WHAT
		Life o)	MDOSINI		Cascade	Md.		U.S.A	•
			COOLIN CTONOLS	0 1 17		eth Roye			
Yes, no, er umkown)	(If yes give war or da	tes of service)	. SUCIAL SEGURITY N						
	DEATH FEATURE		Pro Forth D. C.		Alan Waga	man,	Westm		C. RVAL BETWEEN
	EATH WAS CAUSED	BY: 9	line for (a), (b), and (	(c). ] h m 0	monte	and		ONS	ET AND DEATH
412	6-		7		/				rech
	any, which }	(b)	gorlo	enler	uti				werc_
_		DUE TO	0						
		(c)							was attribus
PARTITION THERS	SICNIFICANICOND	ITTONS CUNTRIE	BUTING TO DEATH BUT	NOTRELA	FED TO THE TERMINAL	DISEASE CUNDIT	TON CIVEN IN P		WAS AUTOPSY PERFORMED?
	WAS UNDERLYING ING CAUSE OF TIFY MEDICAL EX	DEATH AMINER)	DESCRIBE HOW INJU	URY OCCU	RRED. (Enter nature	of Injury in Part	t or Part II of	Item 18.)	
20c. TIME OF Hour a.r p.t		While	Not While	20e. PLAC factor	E OF INJURY (Home, i y, street, office bldg.,	arm, 20f. (Cl etc.)	ty or town)	(County)	(State)
0.1	m.	19 lat wo	rk at work		. 1				
		19 at wo	rk at work	from 7	3/65	19 to	114	196 G th	at (I) (we) la
21. I certif		19 at wo	rk at work deceased				the causes a	and on the date	stated abov
21. I certif	y that (I) (this h	19 at wo	rk at work deceased	and that	death occurred at	P. M, from	STAFF -		stated abov
21. I certife saw the dec	fy that (I) (this hoceased alive Dn. RE	19 at wo	ded the deceased		ATTENDING PHYS. 1 22d. ADDRESS	MED. DIRECTOR	STAFF PHYS.	and on the date	stated abov
21. I certif saw the dec 22a. SIGNATUI 22c. PHYSICIA NAME (1)	ty that (I) (this I) ceased alive Dn. RE CAN'S (NPS) (N   1	19 at wo	ded the deceased 1966,	and that M.D.	ATTENDING PHYS.  22d. ADDRESS  CSTWG	MED. DIRECTOR D	STAFF PHYS. D	and on the date 22by DATE SIC	stated above
21. I certif saw the de 22a. SIGNATUI 22c. PHYSICIA NAME (1)	ty that (I) (this has been been been been been been been bee	19   at wo nospital) attended to the control of the	ded the deceased 1966,	M.D.	ATTENDING PHYS. 1 22d. ADDRESS	MED. DIRECTOR DIRECTO	STAFF PHYS.   Westa	and on the date 22by DATE SIC	M d (State)
21. I certificate saw the decension of the saw the decension of the saw the sa	ty that (I) (this hoceased alive Dn. RE  LIN'S (NP'S) (NP'S) (NATION, 23b. DA ecify)	nospital attendance of the secondary of	ded the deceased 1966,	and that M.D.	ATTENDING PHYS.  1 22d. ADDRESS  C S K W S POR CREMATORY	MED. DIRECTOR D	STAFF PHYS. D	and on the date 22by DATE SIG	e stated above NED  (State)
	b. CITY DR TDW Write RURAL  Vie  d. NAME OF HO  J  NAME OF DECEASED (Type or print) SEX  Female Da. USUAL OCCUPATION HOUSE  3. FATHER'S NAM  Samue 5. WAS DECEASED fes, no, or unknown) NO  18. CAUSE OF PART J. DI  Conditions, If gave rise to cause (a), s underlying caus PART II. DTHERS  20a. ACCIDENT DR CONTRIBUT (IF EITHER, ND	b. CITY DR TDWN (if outside copy write RURAL and give nearest We stminster d. NAME OF HOSPITAL OR INSTITUTION JORDAN NUT JORDAN NUT JORDAN NUT AND SEX 6. COLOR OR RAFEMALE White Da. USUAL OCCUPATION (Give kind of worling most of working life, even if re House Wife 3. FATHER'S NAME Samuel Nichols 5. WAS DECEASED EVER IN U.S. ARME Fes, no, or unknown) (Ifyes give war or da No 18. CAUSE OF DEATH (Enter only PART I. DEATH WAS CAUSED IMMEDIATE CAUSE OF JORDAN OF THE CAUSE (a), stating the underlying cause last.  PART II. DTHER SIGNIFICANT COND 20a. ACCIDENT WAS UNDERLYING CRUSE OF (IF EITHER, NOTIFY MEDICAL EXCEPTION OF THE CONTRIBUTING CAUSE OF (IF EITHER, NOTIFY MEDICAL EXCEPTION OF THE CONTRIBUTING CAUSE OF (IF EITHER, NOTIFY MEDICAL EXCEPTION OF THE CONTRIBUTING CAUSE OF (IF EITHER, NOTIFY MEDICAL EXCEPTION OF THE CONTRIBUTING CAUSE OF (IF EITHER, NOTIFY MEDICAL EXCEPTION OF THE CONTRIBUTING CAUSE OF (IF EITHER, NOTIFY MEDICAL EXCEPTION OF THE CAUSE OF (IF EITHER, NOTIFY MEDICAL EXCEPTION OF THE CAUSE OF (IF EITHER, NOTIFY MEDICAL EXCEPTION OF THE CAUSE OF (IF EITHER, NOTIFY MEDICAL EXCEPTION OF THE CAUSE OF (IF EITHER, NOTIFY MEDICAL EXCEPTION OF THE CAUSE OF (IF EITHER, NOTIFY MEDICAL EXCEPTION OF THE CAUSE OF (IF EITHER, NOTIFY MEDICAL EXCEPTION OF THE CAUSE OF (IF EITHER, NOTIFY MEDICAL EXCEPTION OF THE CAUSE OF (IF EITHER, NOTIFY MEDICAL EXCEPTION OF THE CAUSE OF (IF EITHER, NOTIFY MEDICAL EXCEPTION OF THE CAUSE OF (IF EITHER, NOTIFY MEDICAL EXCEPTION OF THE CAUSE OF (IF EITHER, NOTIFY MEDICAL EXCEPTION OF THE CAUSE OF (IF EITHER, NOTIFY MEDICAL EXCEPTION OF THE CAUSE OF (IF EITHER, NOTIFY MEDICAL EXCEPTION OF THE CAUSE OF (IF EITHER, NOTIFY MEDICAL EXCEPTION OF THE CAUSE OF (IF EITHER) OF THE CAUSE OF (I	D. CITY DR TOWN (if outside corporate limits, write RURAL and give nearest town)  Westminster  d. NAME OF HOSPITAL OR INSTITUTION (if not in Jordan Nursing Home Deceased (Type or print)  SEX  6. COLOR OR RACE  7. MARRIEL WIDOWEL  Da. USUAL OCCUPATION (Give kind of work done ling agost of working life, even if retired)  HOUSE White  3. FATHER'S NAME  Samuel Nichols  5. WAS DECEASED EVER INU.S. ARMED FDRCES? (1) (1) (1) (1) (1) (1) (1) (1) (1) (1)	PLACE OF DEATH a. CDUNTY  Carroll  b. CITY DR TDWN (if outside corporate limits, write RURAL and give nearest town)  Westminster  d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street  Jordan Nursing Home  NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street  Jordan Nursing Home  NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street  Jordan Nursing Home  NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street  Jordan Nursing Home  Middle  Etta  E.  SEX  6. COLOR OR RACE  7. MARRIED NEVER MARRIED  DIVORC  13. USUAL OCCUPATION (Give kind of work done pring most of working life, even if retired)  HOUSE Wife  10b. KIND OF BUSINESS DINDUSTRY  10c. SOCIAL SECURITY NOT DIN	PLACE OF DEATH a. CDUNTY  Carroll  b. CITY DR TDWN (if outside corporate limits, write RURAL and give nearest town)  Westminster  d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  Jordan Nursing Home  NAME OF DECEASED (Type or print)  SEX  6. COLOR OR RACE  Female  White  WIDOWED  WIDOWED  B. DIVORCED  B. SAME  B. DIVORCED  B.	PLACE OF DEATH a. CDUNTY  Carroll  MARYLAND b. CITY DR TDWN (if outside corporate limits, write RURAL and give nearest town)  We stminster  d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  Jordan Nursing Home  NAME OF DECEASED  NAME OF DECEASED  NAME OF DECEASED  NAME OF DECEASED  North  SEX  6. COLOR OR RACE  7. MARRIED NEVER MARRIED  B. Wagaman  SEX  6. COLOR OR RACE  NIDOWED DIVORCED  B. DATE OF BIRTH  WIDOWED DIVORCED  B. DATE OF BIRTH  WIDOWED DIVORCED  11. BIRTHPLACE (in Linear street)  LOUSE WITE  Samuel Nichols  S. WAS DECEASED EVER IN U.S. ARMED FDRCES?  14. MOTHER'S MAI  Elizab  S. WAS DECEASED EVER IN U.S. ARMED FDRCES?  NO  18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a)  DUE TO  Conditions, If any, which gave rise to immediate cause (a), stating the but to underlying cause last.  DUE TO  Conditions, If any, which gave rise to immediate cause (a), stating the but to underlying cause last.  Co. PART II. DTHER SICNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUTNOT RELATED TO THE TERMINAL PART II. DTHER SICNIFICANT CONDITIONS CONTRIBUTING COURRED, (Enter nature of CONTRIBUTING CAUSE OF DEATH (IF ETHER, NOTHEY MEDICAL EXAMINER)	a. CDUNTY  Carroll  MARYLAND  b. CITY DR TDWN (if outside corporate limits, write RURAL and give nearest town)  We stminster  d. NAME OF HOSPITAL OR INSTITUTION (if not in bospital, give street address)  Jordan Nursing Home  MARYLAND  d. STREET ADDRESS  MARK OF DECRASE DECRASE OF PIRST  First Middle Last 4. OATE DECRASE OF DEATH OF STAY IN 1D  Etta E. Wagaman DECRASE OF DEATH OF STAY IN 1D  B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).]  PART II. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a)  DUE TO  Conditions, If any, which gave rise to immediate cause (a), stating the Underlying cause last.  DUE TO  Conditions, If any, which gave rise to immediate cause (a), stating the Underlying cause last.  DUE TO  Conditions, If any, which gave rise to immediate cause (a), stating the Underlying cause last.  DUE TO  Conditions, If any, which gave rise to immediate cause (a), stating the Underlying cause last.  DUE TO  Conditions, If any, which gave rise to immediate cause (a), stating the Underlying cause last.  DUE TO  Conditions, If any, which gave rise to immediate cause (a), stating the Underlying cause last.  DUE TO  Conditions, If any, which gave rise to immediate cause (b) DUE TO  Conditions, If any, which gave rise to immediate cause (b) DUE TO  Conditions, If any, which gave rise to immediate cause (b) DUE TO  Conditions, If any, which gave rise to immediate cause (b) DUE TO  Conditions, If any, which gave rise to immediate cause (b) DUE TO  Conditions, If any, which gave rise to immediate cause (c) DUE TO  Conditions, If any, which gave rise to immediate cause (c) DUE TO  Conditions, If any, which gave rise to immediate cause (c) DUE TO  Conditions, If any William Recombination of Conditions Contribution of Conditions Contribution Conditions Contribution Conditions Contribution Conditions Cont	PLACE OF DEATH a. COUNTY Carroll MARYLAND b. CITY DR TOWN (if outside corporate limits, write RURAL and give nearest town) Westminster d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Jordan Nursing Home Willis St.  NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Jordan Nursing Home Willis St.  NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)  Jordan Nursing Home Willis St.  SEX G. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. ACE (in years last birthday) Female White WIDOWED 100 DIVORCED 8/11/1877 88 yrs.  32. USUAL RESIDENCE (Where deceased lived, if inst a. STATE id.  C. CITY DR TOWN (if outside corporate limits, write we street address)  Westminster  d. STREET ADDRESS  Willis St.  A DATE Month DF Wagaman DF OEATH OEA	PLACE OF DEATH a. CDUNTY Carroll MARYLAND b. CITY DR TDWN (if outside corporate limits, write RURAL and glow careast town write RURAL and glow write RURAL



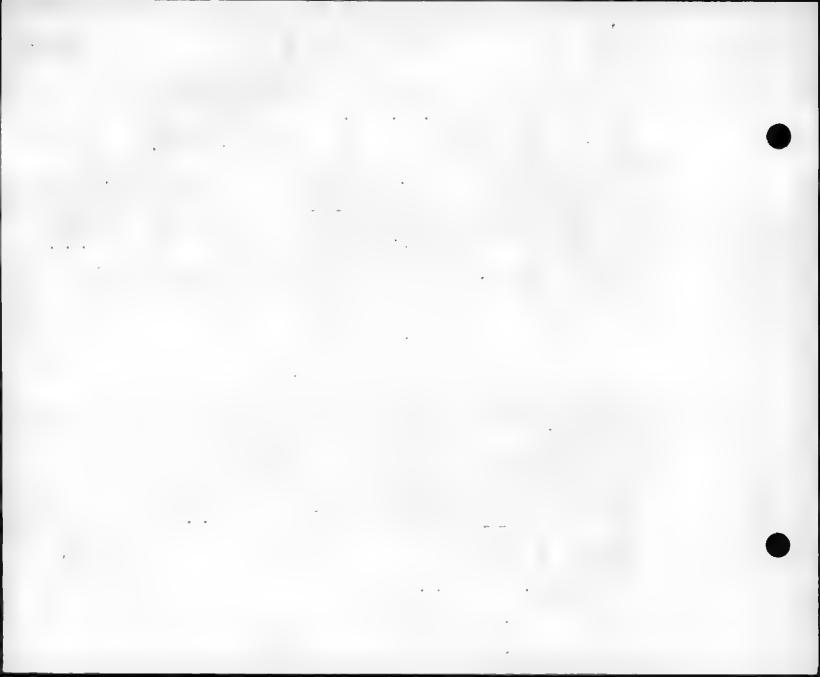
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VR A15 (4) 15M 4-64

	MARYLAND STATE DEPARTMENT OF HEALTH	
	STICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, B	ALTIMORE 1, MARYLAND
00588	CERTIFICATE OF DEATH	ロロドフの

1 -	00000					01 0011						
1.	PLACE OF DEATH a. COUNTY				- 1		ENCE (V	Vhere dece		institution: A	tesidence	before admission)
	Carroll			MARYLANO		a. STATE	land		D. CC	Howa	hre	
-	b. CITY OR TOWN (IF	outside corporate ilm give nearest town)	nits,   c. LENC	TH OF STAY IN 1		c. CITY OR TOWN	l (If outs	lde corp	orate limits,	write RURAL	and glv	o nearest town)
	Sykesvill		divr.	6mo.26dy	9	E114	cott	City	-	13 -	7	
		L OR INSTITUTION (If	not in hospital, g	ve street addres	\$\$)	d. STREET AOORE		OIOY			8	. IS RESIDENCE
	Springfie	ld State Ho	espital			1002	Mon	tgome	ry Rd.			ON A FARM?
3.	NAME OF DECEASED	First	****	Middle		Last	4.	DATE	Mo	nth	Day	Year
	(Type or print)	ROSE		H.	W	HUH		DEATH	Janu	iary 5		19 66
5.			ARRIED NEVI	ER MARRIED X	8.	OATE OF BIRTH		9.	AGE (In year	rs IF UNDER	1 YEAR	Hours Min.
	Female W	hite w	I OOWEO	OIVORCEO 🗍	14-	12-81			84 yrs.		Uays	HOUTS WITH
10a dur	I. USUAL DCCUPATION (	lve kind of work done le, even if retired)	10b. KIND DF BU	JSINESS OR	, ,	11. BIRTHPLACE	(County	& State,	er foreign cour	12. C	ITIZEN (	OF WHAT
	Laborer (	Weaver)	Weo.le	a Mill		Virginia					II.S	.A.
13,	. FATHER'S NAME					14. MOTHER'S N	MAIOEN N	NAME				
	-Unlaneum	Jacob Wn			- {	Unknow	VII.	Kat		McFi]	len	
	. WAS OECEASED EVER			ECURITYNO. 1	7. 1	NFORMANT			Add	ress		
	No		None	Ī	Rec	ords. Spr	ringf	'ield	State	Hosni	tal	
	18. CAUSE OF CEAT	H [Enter only one cau	ise per line for (a)		-						INTE	RVAL BETWEEN ET ANO DEATH
	PART I. OEATH	WAS CAUSED BY: MEDIATE CAUSE (a)_	Arterio	sclerati	ic	heart dis	20250	>				CANC DEATH
	1//200									4944-0		
	Conditions, If any, which any Congralized arteriosclerosis.								V	ears		
	gave rise to imm	edlate (	Uniteral	Zen en de		OSCIEPOSI						
	cause (a), stating underlying cause las	(IIIa)										
8		C)	ONTRIBUTING TO (	EATH BUT NOT R	ELAT	EO TO THE TERMIN	AL OISE	ASECOND	ITION CIVEN	IN PART 1(a)	19.	WAS AUTOPSY
CATI	Schizophrei	nia, parano	id type								YE	PERFORMED?
Ē	20a. ACCIDENT WAS	UNDERLYING []		HOW INJURY OF	CCUR	RED. (Enter natur	e of Infu	rv in Par	t I or Part I	l of Item 18		<u> </u>
CERTIFICATION	DR CONTRIBUTING ( (IF EITHER, NOTIFY)	CAUSE OF DEATH MEDICAL EXAMINER)			50011			.,				
MEDICAL	20c. TIME OF INJUR	Y Month, Day, Year	20d. INJURY OC	CURRED   200, F	PLAC	E OF INJURY (Hom	e, farm,	20f. (0	ity or town	) (Co	unty)	(State)
	Ношг а.т.	19	While Not at work at work	γγπ He ;—. !	ictory	, street, office bld!	g., etc.)					
2	p.m.	at (I) (this hospital)			6	-9-31	30 .	-1 to	1-5-6	6 19	+1-	at (I) (we) last
	saw the decease	7 5	11			death occurred	* 记:九	M de	m the calle	es and on	the date	iat (I) (we) last e stated above.
	228. SICNATURE	d alive oil		J, allu L	Hat	ueath occurred	a L		iii tiie caus		DATE SIC	
	Sherrice	e. ch	uh)		M.O.	ATTENDING PHYS.		CTOR		3/1/	5/6	-
	22c. PHYSICIAN'S NAME (Type)	rill C. Che	eks. M.D.			22d. AODRESS				tate I	osii	tal
238				AME OF CEMET	EDV /	OD CDEMATORY		esvi'		arylan , town or co	Q	(State)
238	REMOVAL (Specify)				ER1	/ - D b	1	E / /		/		Dd b
24	BURIAL FUNERAL DIRECTOR	11/7/146	6 160	ODRESS	PA	FERD. 25a.	REC'D F	Y RECIS	TRAR   25b.	REGISTRAR	'S S GA	ATURE
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MARYLAND STATE DEPARTMENT OF HEALTH

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MES III Carry in James -- At - 114 - 22 - 421 Salvall Standard Comment of the Salvalle of RYLAND STATE DEPARTMENT OF HEALTH

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